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TRACHOMA AND ALLIED EYE AFFECTIONS IN WESTERN QUEENSLAND.

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It is a well recognized fact that in Western Queensland external diseases of the eye are very prevalent, amongst them are cases which resemble in many respects trachoma, and have hitherto been considered as such. As persons affected with these eye troubles are seriously handicapped during their youth, and even in later life, measures have been taken during recent years to cure and to prevent, as far as possible, these complaints amongst school children.

The success of these measures can be gauged by the fact that the incidence of "trachoma" in school children has fallen from 20% to 9.46% within the last three years.

Definition.

There is considerable divergence of opinion as to what constitute the essential clinical features of trachoma.

If a case exhibits chronic inflammation of the conjunctiva and follicles, associated or not with papillary hypertrophy, hyperplasia, cicatrization and pannus, nearly everybody will agree to the diagnosis of trachoma. It is in those cases where not all these features are present that divergence of opinion exists. Fuchs, for example, lays stress on the presence of chronic hyperplasia and secretion; Morax, on the other hand, ignores secretion, emphasizes the presence of follicles, and does not consider the development of scar tissue an invariable feature.

According to Römer, "the nature of trachoma is to develop a chronic inflammatory hypertrophy of the mucous membrane, and to transform the portions of conjunctiva affected into cicatricial tissue," and he even asserts that no disease which does not lead finally to cicatrization can be considered trachoma.

MacCallan states that pannus is always marked, except in the early stages, whereas others do not include this condition in their definition of trachoma.

No one clinical feature is peculiar to trachoma, since any one of the conditions which may be found in cases of trachoma, may be present in other affections of the conjunctiva. Although follicles are almost an invariable accompaniment of certain stages of trachoma, they are also present in folliculosis and in the so-called follicular conjunctivitis, and cannot be differentiated clinically nor microscopically. Pannus may be a strong factor in determining the diagnosis, but many cases of a mild type do not exhibit this condition, which is frequently found also in districhiasis.

Formerly, secretion was considered a constant accompaniment of trachoma; at the present time, most authorities attribute any secretion to the effects of a secondary infection. Papillary hypertrophy usually co-exists with follicle formation in trachoma, but may be present without follicles, and it occurs as well in acute non-trachomatous infections. In those cases where a previously trachomatous eye becomes affected by an acute conjunctivitis, the papillary hypertrophy loses its diagnostic significance.

Though cicatrization is not essential for the diagnosis of trachoma, the tendency of all cases is to the formation of scar tissue. A certain number of mild cases, on the other hand, resolve with the formation of a minimum amount of scar tissue, in spite of the absence of any treatment. And formation of cicatricial tissue may be the result of certain non-trachomatous affections of the conjunctiva, such as those caused by the Morax-Axenfeld bacillus and the gonococcus.

Clinical Description of Trachoma in Western Queensland.

A study of the clinical features of trachoma in Western Queensland makes it apparent that there is, generally speaking, a considerable difference between the manifestations of the disease in Queensland and those observed in Europe. The disease here is characterized by its extreme mildness, and by the very slow development of changes, which may ultimately result in permanent injury to the eye. There is, however, a small proportion of cases which possesses all the clinical features of European trachoma in its severest form.

Owing to the difficulty of observing a sufficient number of cases from the beginning to the end of the disease, a full clinical account of the course cannot be given.

In Queensland, trachoma is invariably chronic, and never shows an acute onset, although acute conjunctivitis, as will be shown later, is a potent factor as predisposing cause.

The early history given by the patients, at any rate in the case of children, is unsatisfactory. The only points of interest which can be elicited are that the patient has suffered from a series of attacks of acute conjunctivitis, and that little, if any, treatment was adopted, which is not surprising, since children suffering from trachoma come from homes where the hygienic conditions leave much to be desired.

As a result of a number of attacks of acute conjunctivitis, the eye gradually drifts into a state of chronic conjunctivitis, characterized by slight injection and relaxation of the mucous membrane and scanty discharge.

The development of follicles and papillary hypertrophy, in addition to these pre-existing conditions, ushers in the stage when trachoma can first be diagnosed clinically. Although papillary hypertrophy may be present without follicles, it does not usually occur alone. The follicles are at first found along the upper edge of the tarsus, and are gelatinous in consistence, becoming firmer at a later stage. The

upper fornix is, as a rule, not markedly affected, and follicles are seldom present on the lower lid. From the edge they spread downwards over the surface of the tarsus, and, excepting in severe cases, do not affect more than the upper half.

The follicles may remain discrete, but it is more common for them to become blended together into a homogeneous gelatinous mass, to which is given the name of Stellwag's brawny œdema. In the milder cases this is confined to the edge of the tarsus, and the rest of the tarsal conjunctiva shows no definite pathological features beyond injection; in the severer cases, the whole of the tarsal conjunctiva is affected. Co-existant with this follicular formation there is a general hyperplasia of the conjunctiva.

Although this condition may remain unaltered for a considerable time, it is usually accompanied by the gradual development of cicatricial tissue, which varies greatly in amount. It is never very marked, except in old-standing cases, whilst in early cases which receive appropriate treatment, the amount of scar tissue is hardly appreciable, the only evidence being the presence of a mosaic of fine white lines on the tarsal conjunctiva. Quite a number of cases appears to have healed spontaneously, all previous treatment being denied, and the only evidence of the former disease is the mosaic referred to above. As one might therefore expect entropion is an unusual sequela.

Pannus is an uncommon feature in the trachoma cases met with here, as compared with those in Europe. It is usually present in old-standing cases of an advanced type where scarring is marked, and which have undergone little or no treatment, especially in those cases in which the conjunctiva is transformed into a homogeneous mass of cicatricial tissue of cartilaginous consistence.

One of the most striking features of the trachoma met with in Queensland is the mildness of the general reaction produced in the eye, and the small amount of discomfort found in the average case. Many children, whose eyes show chronic inflammation, follicular formation, hyperplasia and even Stellwag's brawny œdema, deny that their eyes feel in any way sore.

In short, the Queensland trachoma differs clinically from the classical trachoma, in that the course is very mild and the progress slow, and that such serious developments as marked cicatrization, entropion and pannus only occur in old-standing and neglected cases.

Allied Conditions and Their Differential Diagnosis.

The condition which may give rise to most difficulty in diagnosis is folliculosis. In the majority of cases the problem is easily solved; in others, one has to adopt an expectant policy and observe the results of mild treatment.

Folliculosis, by which is understood a condition in which follicles are present to a variable degree without, however, any signs of inflammation or other pathological features, is very common in Western Queensland. The frequency of this affection can reasonably be accounted for by the constant irritation of the eyes by the dust and glare of the western districts. The condition varies from one in which a few follicles are found on the outer quadrants of the upper tarsal conjunctiva, to one in which both lids and fornices are a mass of follicles, sometimes warty in character. It is astonishing that the majority of children possessing folliculosis, even to the most marked degree, are quite unaware of any feeling of discomfort.

As stated before, the appearance of the follicles does not give any help in the diagnosis, as they differ in no way from those met with in trachoma. Their distribution, however, is usually different. In trachoma, follicles are seldom seen in the lower lid, and, if present, are always more numerous in the upper lid. In folliculosis the reverse holds good, and they are always present in far greater numbers on the lower lid, where they are often seen in numerous rows. This observation is of diagnostic value in those cases in which an acute inflammation is super-added to folliculosis. These cases might be mistaken for trachoma but for the distribution of the follicles, and have been considered by some observers as constituting a distinct disease, which they have designated follicular conjunctivitis. Since, however, folliculosis with super-added acute infection and follicular conjunctivitis are clinically identical, it does not seem justifiable to consider follicular conjunctivitis a definite clinical entity.

A further help in the differential diagnosis between trachoma and non-trachomatous conditions is afforded by the appearance of the injection. In trachoma, the injection of the bulbar conjunctiva is associated with a dirty discolouration, and is confined, or at any rate, most marked in the superior quadrant. In non-trachomatous conditions the injection is of general distribution and brighter in colour.

Ætiology.

The ætiology of trachoma has been for a considerable time a subject of much discussion, and one micro-organism after another has been considered by its discoverer the cause of trachoma. Thus the Koch-Weeks bacillus, Müller's "Trachombazillen," various streptococci and other micrococci, the gonococcus, yeasts and protozoa have each been acclaimed as the causal agent.

On the other hand Blumberg states that recurrent attacks of conjunctivitis diminish the resistance of the reticular connective tissue of the conjunctiva, and cause a continual state of irritation, which finally produces trachomatous changes. But the fact that trachoma has been repeatedly produced by the inoculation of trachomatous tissue into normal human eyes after an incubation period of two to three weeks, indicates that trachoma is a specific disease.

In 1907 Halberstaedter and Prowazek described inclusions in the epithelial cells of the conjunctiva of trachoma patients, which are called trachoma bodies. Since that time the discussion as to the ætiology of trachoma has mainly centred around these cell inclusions.

Halberstaedter and Prowazek consider these bodies the essential ætiological factor in trachoma, and class them in a group of micro-organisms, which they call *Chlamydozoa*. The chlamydozoa, according to

Prowazek, belong neither to the bacteria nor to the protozoa. They are extremely minute organisms, consisting of chromatin only, and are, on account of their minute size, able to pass through filters which retain even the smallest bacteria. Chlamydozoa invade the cytoplasm of epithelial cells, and produce a characteristic reaction product within the cytoplasm, which is, in his opinion, extruded from the nucleus. This plastin, as it is called, forms a mantle around the minute invaders, thus producing the characteristic "cell inclusions," such as those found in trachoma, small-pox, hydrophobia, etc.

The chlamydozoa divide by the formation of dumb-bell-shaped bodies, and development seems to consist of little more than growth in size. The smallest forms are called "elementary corpuscles," and the larger are the "initial bodies."

Halberstaedter and Prowazek state that "The trachoma bodies are found in the cytoplasm of the epithelial cells of the diseased conjunctiva. When smears of scrapings from the conjunctiva are stained by Giemsa's method, certain of the epithelial cells will be found to contain irregular, unhomogeneous bodies, staining dark blue, situated near the nucleus in the light blue cytoplasm. The small round or oval inclusions gradually become larger, assume mulberry form, and, as they increase in size, become looser in texture, the whole mass forming a cap to the cell nucleus. Very small and distinct, red-staining bodies then appear within the inclusions; these bodies increase rapidly in number, while the blue-staining substance gradually disappears. Finally, they fill up the greater part of the cytoplasm, while the blue-staining substance remains as small islands in between them."

Certain of the stages of the trachoma bodies resemble very closely structures found in normal and pathological cells, such as Plimmer bodies in cancer cells, and the archoplasm in gametogenic cells. Certain authorities believe that the trachoma bodies are merely products of cell degeneration produced as the effect of an unknown virus. Other authors consider that these bodies are nests of bacteria, possibly in involuted forms, multiplying in the cell substance. Thus Herzog holds the view that they consist of masses of gonococci, not the gonococci as usually observed, but a specially involuted type, which he designates *microgonococci*. Anna Williams and her co-workers believe that in certain cases at least the cell inclusions are masses of degenerated hæmoglobinophilic bacilli, resembling influenza bacilli.

As a proof that the causative agent of trachoma is smaller than any bacterium which is kept back by a Berkefeld filter, the observation of Nicolle, Cuénod and Blaizot may be quoted. They showed that the filtrate of virus from trachoma cases, using Berkefeld filters impermeable to bacteria, produced typical trachoma in chimpanzees and *macacus inuus* after an incubation period of from one to three weeks.

While there is considerable doubt as to the true nature of the trachoma bodies, there has also been much discussion as to the specificity of these inclusions. They have been observed in cases of non-gonorrhœal and gonorrhœal ophthalmia neonatorum, and even in the cells of the vaginal mucous membrane, particularly in mothers of babies with non-gonorrhœal ophthalmia. They are, moreover, not found in the conjunctival cells of all cases of trachoma, but are most frequently observed in early cases and in acute exacerbations of old cases.

Flemming found eight positive in ten untreated cases, and seven positive in fifty-eight treated cases; Heyman found ten positive in twenty-one early cases, only slightly or not at all treated, four positive in twenty fresh cases of exacerbation, three positive in thirty-two old cases.

The histological features of non-gonorrhœal "inclusion" ophthalmia neonatorum, a non-gonorrhœal ophthalmia with inclusions similar to trachoma bodies, are analogous to those of trachoma, and it is probable that the cases of gonorrhœal ophthalmia neonatorum, showing cell inclusions, are mixed infections where the gonococcus infection is superimposed on the "inclusion" ophthalmia.

It must be remembered that trachoma bodies in some stages resemble closely inclusions found in normal and degenerating cells. It may therefore be inferred, at least in some cases, that inclusions of the latter type have been described as trachoma bodies in non-trachomatous conditions.

It would seem that there is considerable evidence for the specificity of trachoma bodies, and the finding of these bodies in the conjunctival cells of cases resembling trachoma may be taken as presumptive evidence that the cases are really trachomatous in nature. Besides, Greef and Wolfrum have produced typical trachoma in man within a few weeks after inoculation with trachomatous material, and in their cases trachoma bodies were observed after the disease had become established.

Microscopic and Cultural Examination of the Conjunctival Affections of School Children.

Scrapings, and, in a number of cases, cultures, were made from the eyes of 49 school children and one adult, suffering either from trachoma or acute conjunctivitis, chronic conjunctivitis, folliculosis and other eye affections, in Winton, Hughenden, Richmond and Cloncurry, all towns in Western Queensland.

Scrapings were taken from the superior tarsal conjunctiva with the edge of a No. 2 cover slip, and smears made on slides. The smears were fixed with absolute alcohol, and stained with Giemsa solution (1 drop in 1 c.cm.). A few of the smears were stained by Lindner's method, equal parts of undiluted Giemsa's solution and of ½% solution of acetic acid.

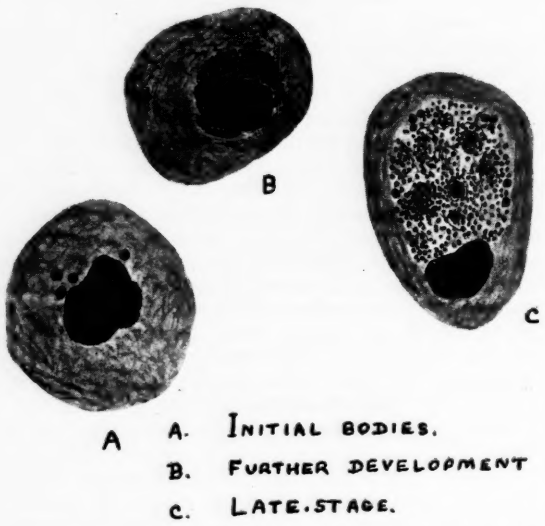
For the cultures, the tarsal conjunctiva was well rubbed with sterile gauze swabs fixed on wire. The swabs were then put into broth tubes and afterwards rubbed over the surface of solidified serum and blood agar. The culture tubes were incubated at 37° C., and examined at the end of 24 and 48 hours. The great distances travelled and the absence of facilities prevented a more thorough cultural study, and the results obtained are somewhat inconclusive. In all, 22 cases of eye effections were examined culturally, and nothing was found that

might not be present in normal eyes, with the exception of the Koch-Weeks bacillus, grown from two cases of trachoma (see Table I.).

Table I.

	Trachoma Cases.	Non-trachomatous Cases.
Cases Examined	18	4
Xerosis bacillus	12	3
Koch-Weeks bacillus	2	—
Pneumococcus	1	—
Streptococcus	3	—
Staphylococcus albus and aureus	5	—
Other cocci	1	—
Other bacilli	3	—
No growth	3	1

The stained smears were searched for trachoma bodies, and these bodies were only found in cases previously diagnosed as trachoma. In none of the cases were trachoma bodies abundant, and in several they were found only after prolonged search. They



were, however, in every respect typical, and all the stages described by Prowazek were observed. They were found most frequently in cases showing Stellwag's brawny œdema (Table II.).

Table II.

	Cases.	Trachoma bodies found.	Trachoma bodies not found.
Acute conjunctivitis	5	—	5
Sub-acute conjunctivitis	3	—	3
Folliculosis	3	—	3
Folliculosis, with acute conjunctivitis	3	—	3
Early trachoma—Precicatricial stage	6	4	2
Intermediate trachoma — Scarring commencing	11	8	3
Late trachoma—Almost healed	12	1	11
Advanced trachoma — Marked scarring and pannus	3	3	—
Late trachoma, with acute conjunctivitis	4	1	3

Among predisposing causes of trachoma the most important are the effects of dust, dirt, flies, glare, and the prevalence of acute catarrhal conjunctivitis, all of which are prevalent in the western districts of Queensland, to which parts trachoma is practically confined. Dust, flies and glare are almost constant features, and acute conjunctivitis is extremely prevalent during certain seasons of the year. In addition, perhaps 90% of the patients belong to families in which the want of cleanliness is obvious, whilst well-cared-for children rarely contract the disease.

It is striking that the nearer one approaches the coast, the fewer are the children suffering from conjunctival affections. This distribution of eye diseases seems to be directly related to the prevalence of flies. Flies are found in greatest numbers in black soil and salt-pan country, and are less evident in ironstone and desert country.

From these facts, it may be inferred that flies play a rôle in the transmission of the infection, and it is in all probability not the common house fly, *Musca domestica*, but a smaller species of Musca, commonly known as the "bush fly."

Probably the most important predisposing cause of trachoma is acute conjunctivitis. This disease, of itself, if appropriately treated, is of little moment; the danger lies in its neglect, when it tends to drift into a chronic state, in which subsequent acute attacks are common, and the resistance of the conjunctiva to secondary infections is reduced.

In almost all cases of trachoma a history of frequent attacks of acute conjunctivitis can be obtained. The question must therefore be raised whether this series of acute infections leads finally to the condition hitherto regarded as trachomatous, the whole series being the expression of a continuous non-specific infection, or whether these acute attacks only reduce the resistance of the conjunctiva, and prepare the ground for the reception of the trachoma virus.

In support of the former view, the following observations may be made:—

(1) The transition from acute conjunctivitis through chronic conjunctivitis to trachoma is continuous, and the point at which trachoma begins is certainly not definite.

(2) The disease, as found in Queensland is, on the whole, extremely mild; cases of acute trachoma are not observed, and only a small proportion of the cases show the changes typical of advanced, classical trachoma.

(3) The distribution of the disease is co-extensive with that of acute conjunctivitis, and the greatest number of cases of trachoma are seen in the far western towns, where acute conjunctivitis is very prevalent.

(4) As compared with trachoma in Europe, the disease in Western Queensland has an extremely feeble contagiousness.

In spite of these observations, it seems more likely that the second view is the correct one, *i.e.*, that the acute conjunctivitis prepares the ground for the infection with the trachoma virus. Although the disease is more gradual in its progress, and milder;

every clinical feature of typical, classical trachoma can be observed, if a series of cases be studied; moreover, small numbers of advanced cases show all the lesions of the worst type of trachoma.

That the mild course of the disease in Queensland does not exclude the diagnosis of trachoma is strengthened by the observations of Foley, Sergent and Meslin among the Haratin tribe in the Sahara. Amongst these natives trachoma is prevalent, but corneal complications are very rare, and spontaneous cure, without cicatricial complications, is the rule.

Another argument in favour of the specificity of "trachoma" in Queensland is that the trachoma bodies of Prowazek and Halberstaedter were found in 17 out of 36 cases, clinically diagnosed as trachoma, and were never found by us in non-trachomatous conditions.

The extreme mildness of the majority of the cases of trachoma in Queensland, the gradual progression, the feeble contagiousness and the association with acute conjunctivitis, are features in which it differs from the classical type. These features can be explained on the assumption that the trachoma virus in Queensland is of an attenuated type. In our opinion, attacks of acute conjunctivitis so lower the resistance of the conjunctiva that the attentuated virus which cannot infect a normal, healthy conjunctiva, is enabled to obtain a foothold.

Conclusions.

(1) Chronic conjunctival affections are very prevalent in Western Queensland. Many of the cases are clinically analagous to European trachoma, but differ in their extreme mildness.

(2) The opinion that the disease is true trachoma is supported by the finding of trachoma bodies, which many authorities consider pathognomonic of the disease. These trachoma bodies were observed by us only in cases which exhibited the clinical features of trachoma, and which were diagnosed as such.

(3) The mildness of the disease can be accounted for by the assumption that the virus is of an attenuated type.

(4) Acute conjunctivitis is the most important predisposing cause in the incidence of trachoma. Repeated attacks of acute conjunctivitis lower the resistance of the conjunctiva, and the attenuated trachoma virus, though unable to attack the normal eye, is able to establish itself on an already weakened conjunctiva.

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SURGICAL DISORDERS IN INFANCY AND CHILDHOOD IN GENERAL PRACTICE.*

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This is a subject on which I might be accused of repeating myself, seeing that a good deal of what I am about to say has appeared elsewhere, *i.e.*, in the *Transactions of the Australasian Medical Congress*, 1911, and in the columns of the *Australasian Medical Gazette*. I have also spoken elsewhere on the scope of surgery in a children's hospital, but here I wish to dwell on the subject from the point of view of the general practitioner. In the articles referred to, the duties of the attendant general practitioner were emphasized, and also the position and responsibilities of the operating or consulting surgeon. Each in his particular sphere may assist the other, each having his responsibility and duty, which are equally important.

I had a case the other day, alarming in appearance—a large exomphalos or hernia into the tissues of the umbilical cord. This was viewed very gravely by the attending obstetrician, and a bad prognosis was given. The patient was sent to the hospital as a serious case, where the hernia was found to be quite reducible under an anæsthetic. The cord was tied, and recovery was perfect. Such a case need not have come for special treatment. As it was, the operating surgeon got great *kudos*, which might easily have belonged to the ordinary medical attendant, whose reputation, in this case, I fear, may have suffered. Cases of exomphalos in a minor degree are common, but when extensive are alarming. It sometimes happens, as in this case, that reduction is easy; in others, important abdominal organs, notably the liver, are included, and here the prognosis is grave. At other times, apart from the question of contents, the mass is difficult to reduce; this necessitates an open operation, which adds greatly to the seriousness of the case. The appearance of such a congenital defect need not alarm the obstetrician, and an attempt at reduction should be made. The question of an anæsthetic at such an early age, even hours only, need be no deterrent, although complete anæsthesia in a new-born infant is frequently difficult to obtain. It is in connexion with congenital defects and diseases of the newly-born that the general practitioner is often called in to perform what might prove to be life-saving operations. Imperforate anus is a congenital condition demanding immediate notice and operation for its relief. Many of the cases are only of a minor degree, needing puncture with a tenotomy knife for evacuation of retained meconium. Others show an association with a deficiency of the lower bowel, and need colotomy, either right or left sided. The prognosis

* Read before the Northern Medical Association, at Glen Innes, on April 17, 1914.

in these cases is grave, but the operation is generally imperative to save the child from the agony of death by unrelieved intestinal obstruction. Spina bifida presents an alarming condition to both obstetrician and parents. Advice is naturally asked, and here conservative advice and treatment should be given, as even the most successful operations are followed by paralysis, talipes or hydrocephalus; indeed, such a condition often co-exists with the deformity.

Hare-lip and cleft palate are obvious deformities, the former, if double, particularly obtrudes itself. This, in addition to its unsightly appearance and mental effect on the mother may interfere seriously with proper sucking on the part of the infant. An attempt to repair a hare-lip in a new-born infant is the duty of the medical attendant. A knowledge of the parts, with their embryological bearing, and a certain amount of ordinary surgical dexterity, can quickly transform a hideous-looking deformity into a decent-looking baby, able to suck, and at the same time can effect a material change in the mother's mental condition, which is of great importance at the time. I do not contend that as neat an operation can be performed at this time in an emergency as we are able to do in a prepared subject, with all the necessary help at our hands, but such gross deformities as occur in double hare-lip can be quickly and easily rectified with the use of sharp, curved scissors and fishing gut or wire sutures, which the obstetrician always has in his bag. Such a proceeding will likely be only temporary, but the replacement of a prominent fronto-nasal process and general approximation of the edges of the cleft lip will help greatly a subsequent, properly planned, repairing operation.

Circumcision of the newly-born is often a matter of routine, and, further, is generally expected of the general practitioner.

Umbilical hernia tends to spontaneous cure, and also some cases of inguinal hernia. However, many cases of inguinal hernia in the new-born are extensive, and demand early operation. Here, the simple operation of tying the sac, thereby obliterating the persistent vaginal process, is all that is needed.

Cleft palate operations, to my mind, never appear to be matters of urgency; they are unwelcome cases at any time to the operating surgeon, the results being more often than not disappointing.

Deformities of the limbs noticeable at birth and requiring immediate treatment by the general practitioner are chiefly some form of talipes. The first-aid surgery necessary is either operative or instrumental. When a marked case exists at birth, it is often easy to restore the shape of the parts to normal by manipulation and to retain the same by some light splint appliance or by the use of zinc oxide plaster. Should this fail, a suitable tenotomy may have to be done by the medical attendant. The circumstances surrounding these cases should dictate how far the ordinary medical attendant should act; one of the chief of these is that the child is on the breast, and cannot travel to a larger centre without the mother.

Deformities of the upper limbs, such as birth palsy, are capable of improvement by radical operations, but these are matters for a specialist, and are never very urgent. Sterno-mastoid tumour in the newly-born tends to spontaneous cure: but one of its consequences, *i.e.*, wry neck, may ultimately need operation, such as neurectomy of the spinal accessory, or excision of the sterno-mastoid muscle.

Congenital dislocation of the hip-joint, as a rule, only concerns the general practitioner from the point of view of diagnosis. The treatment is long and tedious, and consists in reduction by manipulation, after careful determination of the position of the head of the femur and the acetabular capacity by expert X-ray photographs; further retention in an improved position by appliance, and only, as a last resort, open operation. Such measures can only be undertaken when the parents are prepared to allow the child to spend an unlimited time in hospital, with frequent examination by X-rays.

Passing from the cases which are obvious, I have been in the habit of reviewing the surgical affections of childhood as they affect the various systems. Some are congenital, others acquired, and it is everybody's experience that children are liable to all ailments incidental to adults.

The digestive system, extending from the mouth to the anus, may show anything from tongue-tie to ischio-rectal abscess. Stenosis of the œsophagus—commonest in children from the swallowing of hot water, caustic acids or alkalies—may lead to starvation, and need mechanical treatment, such as the passage of bougies and even gastrostomy to prevent death by starvation. The prognosis is grave. Children seem to be free from gastric and duodenal ulcer, and cancerous ulceration of the stomach, but hydatid cysts in any position may be expected. Foreign bodies in the food passages are naturally common; those large enough to enter the stomach, such as coins smaller than a halfpenny, buttons, pins, etc., generally pass *per anum* in a few days, after careful dieting with cotton wool puddings or sandwiches. As the history is not always reliable, an X-ray screen examination is advisable, if possible. The coin most suitable in size for catching in the œsophagus is a halfpenny; it is generally arrested at the level of the cricoid cartilage, may occasionally be felt, and gives symptoms of inability to swallow any solids easily, but allowing fluids to pass by revolving on its diameter. If not vomited in a reasonable time, it should be removed by a coin-catcher, after its presence has been demonstrated by X-rays. The flexible whalebone or light steel instrument with the moveable swivel on the end is the best. It should be passed down the œsophagus during anæsthesia, until it is arrested by the foreign body. A little extra force will then rotate the coin on its diameter, and the instrument can pass on. After the operator has felt it pass the obstruction, a gentle withdrawal will arrest the instrument. This means that the edge of the coin has been grasped by the swivel. A forcible withdrawal should then be able to bring the coin into the fauces, and the finger can do the rest. Rough handling can easily injure the mucous membrane,

and mediastinal infection follow. In my experience, a halfpenny, or some coin or button about the same size, is the most likely foreign body to become impacted in this way. Should efforts to remove a foreign body by the mouth prove of no avail, it should be removed by a dissection through the neck; this is often difficult, and infection of the wound through the opened œsophagus is likely to occur.

Congenital hypertrophic stenosis of the pylorus is essentially a disease of infancy, and here the medical attendant is called upon to diagnose the condition and decide whether medical or surgical measures are indicated for treatment. The symptoms are evident, and come on shortly after birth. They usually show themselves when the nurse leaves. It seems likely that the condition may be the result of too often repeated breast-feeding, resulting in an undue strain on the pyloric ring and hypertrophy with stenosis results. The symptoms of projectile vomiting and visible peristaltic waves, and the presence of a palpable pyloric tumour, with marked constipation, are the main features in the diagnosis. Sometimes judicious feeding, combined with lavage of the stomach, leads to a cure, and the tumour may disappear. If the case is obstinate, and wasting and vomiting continue, the question of operation must be considered. The mortality, as you know, is high, anterior gastro-enterostomy giving the best results.

Appendicitis is common in children, mostly in big boys and girls, but not so much in infants or children in arms, it being well recognized that appendicitis is preceded by or associated with digestive indiscretions or upsets. As soon as the child gets out of hand in the matter of diet, intestinal disturbance from food indiscretion is likely to occur. The majority of cases of acute appendicitis, therefore, affect children from six to twelve years. The first recognized attack is acute, probably because any antecedent ones may have been aborted by the timely use of castor-oil. The public knows the use of castor-oil, and in young and old cases that do not improve as a result of its administration are considered cases for the doctor. In children, acute appendicitis more often gives rise to general peritonitis. This is partly because abdominal pain is so common in children, and thereby aid is called in later, and I think, myself, the protective mechanism of the abdomen, notably the omentum, is not so strong and extensively developed as in adults. There is nothing distinctive in the operation for the relief of appendicitis in children. Removal of the appendix is advisable in all cases where it does not add to the risk of operation and drainage in all cases of doubt.

Congenital dilatation of the colon, or Hirschsprung's disease, occasionally, is seen at a children's hospital. The marked feature of these cases is the obstinate and chronic constipation; the subjects are generally poor ones for operation, they react badly, and their abdominal wounds do not heal well. Total removal of the large bowel has been tried, but the results of operation and the cases generally are most unsatisfactory.

Intestinal obstruction in its various forms may be met with in children. Of course, intussusception is particularly an ailment of infancy, the typical case occurring in a healthy-looking, breast-fed baby, and it has its unmistakable diagnostic points. On this subject I will not weary you at length, as it has been exhausted everywhere. Sufficient it is to remind you that the general practitioner is concerned not only with the diagnosis, but the treatment, which is always immediate laparotomy. The other forms of intestinal obstruction, as peritonitis, do not offer many distinctive features for review.

Respiratory System.—Excluding cases of diphtheria, there are many occasions on which laryngeal obstruction has to be dealt with in children, due to foreign bodies. The operation indicated is generally tracheotomy, the details of which are common student knowledge. Obstruction in the air-passages lower down, *i.e.*, in the trachea and bronchi, chiefly from foreign bodies, calls for immediate first-aid treatment, and rarely for operation. There are, of course, certain cases from extrinsic pressure, *e.g.*, persistent thymus, mediastinal growth, etc., for which little can be done. The later results of pneumonia, empyæmia, abscess of the lung and bronchiectasis, have often to be dealt with by rib resection and drainage, which is an operation of general surgery.

The lymphatic gland system is liable to quick and sometimes extensive hypertrophy, inflammation and suppuration, as a result of anything affecting the drainage area of any particular set of glands, those of the posterior triangle becoming quickly affected from any affection of the scalp, such as pediculosis or eczema. The deeper carotid glands enlarge, suppurate or perhaps caseate, as the result of nasopharyngeal affections, *e.g.*, adenoids or tonsillar affection; the femoral glands from affections of any part of the lower extremity, and the inguinal glands from the genitals—in all varieties of this class of trouble dealing with the primary source infection is indicated. In the neck, when the deep carotid glands remain permanently enlarged, they are often looked upon as tubercular, and when they break down and suppurate or caseate, tubercle bacilli are frequently demonstrable, yet the subjects do not, as a rule, show any constitutional signs. The surgical or operative treatment consists either in puncturing fluctuating spots and awaiting the result of growth on the part of the child, combined with suitable hygienic measures, or the total excision of the affected gland and its neighbours, if their structure should appear doubtful. One course is conservative and the other radical. The choice of methods depends on the surgical powers of the doctor; by either the end result is good. The former is more satisfactory than the latter in that less scar formation is left.

The locomotor system is frequently attacked in children, and here we may meet with one of the many pitfalls of medical practice, in the form of some acute invasion of a bone or joint, wherein the diagnosis of "rheumatism" is so easy and acceptable to parents. It is my experience, and that of others

who have dealt largely with diseases of infancy and childhood, that rheumatism is by no means a common affection in this class of patient, and, further, that its occurrence in a single joint is almost unknown. Injuries to bones and joints show no special features in children, but acute disease often selects them in preference, owing to the existence of epiphyseal cartilage. Mr. Edmund Owen, of London, has especially emphasized this in the home journals, and warned practitioners of the frequent error of diagnosing rheumatism and treating with salicylates a condition that needs incision and frequently opening of the bone at once.

The genito-urinary system is not exempt from common surgical ailments in childhood. Stone in the bladder is frequently seen, and as often missed, especially as the function of micturition in children is irregular and erratic, and sufficient notice is not taken of it by parents and practitioners. A new growth in connexion with the kidney, generally a sarcoma, is the common cause of a gradually increasing tumour formation in the abdomen, and is often symptomless.

New growths and parasitic deposits, generally hydatids, may occur in childhood, as in adults, and the possibility of their existence must always be recognized.

If in these few observations I have helped in any way to enlighten you on any details in this subject of surgical disease in children, I am pleased, and thank you for your patient hearing.

Reviews.

SANITARY SCIENCE.

The object of Husband's text-book of Public Health[1] is to meet the requirements of the medical student and the practitioner reading for the diploma of Public Health. The ever-growing scope and importance of preventive medicine have led Dr. Hope to endeavour to cover the essential parts of the subject in as simple and useful a manner as possible. The first seven editions appeared as a section of Husband's Forensic Medicine. The eighth edition appears as a separate volume, in expectation that it will thereby prove more serviceable to the student. In the compass of 262 pages, printed in clear type, it gives a concise, practical and thorough account of the subjects with which the medical officer of health requires acquaintance. The volume opens with a readable chapter on sites and soils. This is followed by a brief account of the construction and sanitation of buildings. The next chapter deals with sewerage and the disposal of sewage and refuse. Recognizing that the disposal of sewage from large towns will be controlled by experts, the author has paid special attention to the problem as it is met by the health officer of small towns and rural areas. The chapter on water covers all the matters that fall within the province of the medical man. A brief summary of the usual methods for examining drinking waters can be commended. The fifth chapter is headed air, ventilation and warming. A study of this chapter would be useful in this State,* where too little attention is paid to the ventilation of private and public buildings. A summary is given of the recent results obtained by Haldane and Leonard Hill on the determining causes of stuffiness in rooms. The interpretation of meteorological records forms part of the account of the influence of climate. Vital statistics and their use in hygiene are dealt with within the compass of 30 pages. The zymotic diseases are briefly review, and sound advice is offered in regard to the prevention of their transmission. Attention is paid to the types and duties of hospitals, in addition to the usual information on their sites and construction. The chapter on foods is too short, and the author might, with advantage, enlarge this section in the next edition. School hygiene and the medical inspection of schools are dealt with in chapter ten, which contains a summary of the instructions given to teachers, both to impart to their pupils in lessons on hygiene and to ensure the health of the scholars. Military and naval problems are not neglected. A well-arranged digest of sanitary law concludes the volume. This book can be recommended to every health officer who requires a practical, yet brief, account of the subject-matter of his duties.

[1] Text-book of Public Health (late Husband's), by E. W. Hope, 1915. Edinburgh: E. & S. Livingstone; Demy 8vo., pp. 267, with 54 illustrations. Price, 5s. net.

* New South Wales.

Notes on Books.

THE MEDICAL DIRECTORY, 1915.

Messrs. Butterworth & Co., of Sydney, have issued a medical directory of Australia, New Zealand, etc., which is a very different publication to its predecessors. The Directory contains a great deal of information, in addition to the personal information usually found in a medical directory. A number of pages are devoted to the ethics of medical practice. Many of the dicta in this chapter should govern the professional conduct of practitioners, and it is quite safe to follow the indications contained therein. The concluding part of the chapter is a reprint of an article by Dr. R. H. Todd, of Sydney, on "Consultants and Consultation." This article is the best exposition of the subject in existence.

The list of medical periodicals requires revision and amplification. A great deal of information concerning the Commonwealth is given, including some statistics of population, etc., some meteorological observations, various vital statistics, etc. Charities, public health, naval and military matters, etc., are dealt with in turn, and a special chapter is devoted to the constitution of the Federal Committee of the British Medical Association.

The names, addresses, degrees, etc., of each practitioner are given in geographical sequence in each State. The details of the University, the Department of Public Health, the Associations and Societies, Hospitals, and Coroners of each State are dealt with separately, and are followed by a *précis* of the Medical Act. At the end of the volume is an alphabetical list of medical practitioners in Australia and New Zealand.

This publication will be found to be of considerable use to medical practitioners and others. The publishers are to be congratulated on the excellence of the work achieved. In view of the complete reorganization, it is scarcely surprising that its appearance this year was delayed for more than five months. No doubt the few small defects will be remedied at an early date, and the 1916 edition will appear at its proper time.

MELBOURNE HOSPITAL.

The announcement of an exceedingly generous gift to the Melbourne Hospital was made at the fortnightly meeting of the Hospital Committee on June 8, 1915. A letter was read from the Trustees of the Edward Wilson estate, in which the writers informed the Committee that a further gift of £10,000 would be made toward the building fund. The Melbourne Hospital would cost £286,519, according to the architect's estimate. The completion of the building could, it was announced, be undertaken, save in respect to one small block. The Chairman of the Committee pointed out that no less a sum than £135,000 had been presentd by the Trustees of the Edward Wilson estate. A resolution expressing the Committee's gratitude and appreciation of the generosity of the trustees was passed at the meeting. It is very gratifying that the hospital can now be finished without the encumbrance of a debt, and Melbourne has every reason to congratulate itself on the possession of one of the finest hospitals in existence.

The Medical Journal of Australia.

SATURDAY, JULY 10, 1915.

Sexual Education.

An important discussion on the subject of venereal disease stands adjourned in the South Australian Branch of the British Medical Association. In other States various steps are being considered in connexion with this highly important matter, and the public has had it brought violently to its notice both in relation to the sexual excesses of the soldiers on the field of battle and through the sociological movement which has taken this subject as one to be dealt with without delay. Various suggestions have been brought forward within the past few years, including notification, control, and night clinics. A further suggestion is in the education of the public, and closely associated with this matter is the question of education of the child in sexual physiology. An able article on the lastnamed subject has appeared in the *Western Women*, of June 1, 1915. This publication has been in existence for less than one year, but promises to serve a highly useful purpose in bringing to women living in the bush information of a political, social and economical nature. The article referred to is signed "Practitioner," and bears the stamp of the work of a careful observer and an able thinker. The writer pleads for judicious and early information on sexual physiology, and above all for truth in the replies by parents to the enquiries by children. The danger of learning too late, dangers of prostitution, venereal infection and sexual precocity, leading to perversion, are real, and the quotation of Bloch is made that it is "Better a year too soon than an hour too late." How and when the child should be taught the laws of reproduction, and the significance of sex, are questions which must find answers varying according to the environment of the child and the attitude toward sexual matters of the parent. Unanimity will probably never be attained.

We are not inclined to the belief that this expedient will stamp out prostitution or eradicate venereal disease. But there is little doubt that cautious and correct information at a suitable time, and under auspicious conditions, will effect a saving of individuals from the dangers of both ignorant action and careless exposure to the risk of infection. More may be expected from educational measures in girls than in boys, but even in the latter harm cannot follow, provided that the teaching is accomplished in a proper manner, and in a number of instances the child may be induced to adopt a clean attitude of mind and a healthy conception of sex functions.

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HOSPITAL ACCOMMODATION FOR THE WOUNDED.

The intentions of the military authority in regard to the scheme to be adopted for the care of the returned wounded and sick soldiers has occupied the attention of the Minister of Defence during the past few weeks. On the occasion of his visit to Sydney, on June 29 and 30, the Minister discussed with Sir Thomas Anderson Stuart the advisability of utilizing the Royal Prince Alfred Hospital, with its full equipment and staff. The advantages of this as compared with a military hospital organized *ad hoc* and staffed by men who may be available is obvious. Moreover, as we pointed out last week, the need for military discipline in the case of physicians and surgeons treating sick or wounded men can only be of importance in so far as the control of the department is concerned. Sir Thomas offered a large number of beds at the Royal Prince Alfred Hospital to the Department of Defence, and from the reply given it would appear as if this offer were favourably received.

We are informed that the following letter has been addressed to the Director-General of Medical Services by Sir Thomas, in his capacity of Chairman of Directors of the Royal Prince Alfred Hospital and Dean of the Faculty of Medicine:—

June 30, 1915.

Dear Sir,—

Following the interview which I had with the Minister of Defence yesterday, I think it will be well for me to state for your information the position as regards the question of hospital accommodation for returned soldiers as submitted by me to him.

It, in various ways, has reached the medical public in Sydney that it is contemplated by your department that what amounts to practically new hospitals should be instituted, and that such hospitals should be managed and staffed entirely by Army Medical and Army Nursing Services. If this be carried out, it would mean that the offer of this hospital to provide beds up to 150 at once, and, in case of the necessity for urgent suitable cases, up to 500 beds, would not be accepted. I am assuming that the cases sent will be in the nature of acute cases, or such as require active treatment.

I might point out that it takes very considerable time to furnish and otherwise equip and bring into active operation an efficient, up-to-date hospital; so that it appears to me that it would be much better for everyone concerned, the military and the patients alike, were such an institution as this availed of to its utmost capacity rather than that you should think of instituting a corresponding number of beds in another institution, and still more if you have to erect buildings, as has been the case, for instance, in Victoria.

But difficulties will arise not alone with the material but also with the personnel. You will have great difficulty in obtaining the services of an efficient resident

staff for any military hospitals such as I understand are in contemplation, and with regard to the resident medical staff, may I point out that these are just the men who should not stay here, but are wanted at the front, whereas we have a resident staff, so organized that it does not need to be added to, and with regard to the honorary staff these comprise the highest talent available in the profession in Sydney.

To the arguments adduced, the following might be added. In the event of the existing great public hospitals being utilized, there would be less strain on the profession, and consequently more men would be free to take on military duty, either with the R.A.M.C. or with the Australian forces. The demand for more doctors continues, and we regret to learn that men who are physically and scientifically suitable are being told that their services are not required. As long as the requirements are not covered by the supply, no healthy and otherwise satisfactory men should be refused.

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THE CHARGES AGAINST CAPTAIN SCHLINK.

For some time past, rumours and indefinite statements in regard to the condition of the Liverpool camp and of the Military Field Hospital have found their way to Sydney and thence to other parts of the Commonwealth. These rumours and sharp criticisms were probably not entirely without foundation, as is usually the case, but there seems to be little doubt that they were greatly exaggerated. The conditions were certainly not ideal up to a few months ago, and, in addition to the complaints from outside, complaints were made from within that many necessities were not forthcoming. An epidemic of morbilli occurred shortly before the 2nd General Hospital left, in the charge of the P.M.O. of New South Wales (Col. T. Fiaschi), and the death of some of the men at Liverpool gave rise to increased charges against the administration and management.

On March 12, 1915, Captain H. H. Schlink, A.A.M.C., attached to the 40th Army Medical Corps, was ordered to take charge of the Field Hospital at the Liverpool Camp for one month. This officer has previously been on duty as senior medical officer in charge of permanent troops and of the Garrison Hospital, in the place of Lieutenant-Colonel Mullins. In spite of his repeated applications to be returned to his unit, in order that he might minimize the financial sacrifice which service at the Camp was entailing, Captain Schlink was kept at the Field Hospital up to the end of June, 1915. The hospital is said to have improved in every way under his administration, and its size and scope have been very largely extended.

Senator Millen was the first to make attacks on Captain Schlink, in the Federal Senate. An opportunity to refute the statements was denied. On July 1, 1915, Mr. R. B. Orchard, M.H.R. for Nepean, New South Wales, made a violent attack upon the camp and hospital, and especially on Captain Schlink. The first complaint was the shortage of overcoats and underclothing for the men in camp at Liverpool. The next point brought forward was an assertion that the supply of rifles was quite inadequate, both in regard to number and quality, and that the men were sent off after short courses of training. Next, Mr. Orchard turned his attention to the condition of the huts, which he said were draughty and comfortless. Hundreds of cases of pneumonia had gone through the military hospital, and chest and throat troubles were more common at the camp than any other illnesses.

Mr. Orchard then made some specific charges, which involved Captain Schlink. In the first place, he stated that the sick men at the Camp were lined up for inspection at 6.55 a.m., or if they were not in the ranks at that time, they would have to wait until 5 p.m. for a doctor, and, in the meantime, would be made to perform their ordinary duties. At the dispensary, unless a soldier brought a bottle with him, he would not receive any medicine. The doctor in charge was callous and indifferent, and the men got no sympathy. The men said that their treatment was owing to the fact that the doctor in charge was a German or of German parentage, and German in sympathy. His name was Schlink. The Minister for Defence knew that only the week before he was reported for having made disloyal utterances at a certain club, and that he was also reported to have relatives fighting with the Germans. He believed that the relatives were brothers. His presence in that hospital was an insult to Australia and an outrage to the boys in camp. He should be removed immediately.

We have made full enquiries into the charges directed against Dr. Schlink, and are prepared to prove that they are one and all untrue.

On June 28, 1915, while the charges previously made against Captain Schlink were still awaiting refutation, he received an official order from the P.M.O. of the 2nd Military District to hand over the hospital to Captain C. H. E. Lawes, A.A.M.C., and to return to his unit. To this order, Captain Schlink replied, requesting, not for the first time, to be given an opportunity, by court martial or otherwise, to clear himself of the charges made against him before the order was given effect to. In spite of previous assurances that he would be given the opportunity sought, he was then informed that a full-time officer was required, that no charges had been made, and that the order would take effect forthwith. Captain Schlink expressed his willingness, under the circumstances, in spite of the great financial strain upon him, to take on full-time duty. Since this redress was denied him by the P.M.O., he applied to the District Commandant, who informed him that no demobilization order had been authorized. On July 3, 1915, the announcement of the appointment of Captain Lawes to the position of medical officer in charge of the Field Hospital, in place of Captain Schlink, appeared in the public press. Captain Lawes, who is an officer junior in service to Captain Schlink, was given the rank of major. On July 5, 1915, the announcement was made that Captain Schlink, officer commanding the Field Hospital at Liverpool, who had been on sick leave recently, had resumed duties at the camp on the 4th.

Before Captain Schlink obeyed the demobilization order, the men at the hospital made a great demon-

stration in his favour, and the scene as he departed was evidence of his popularity. Moreover, when he had, some short time before, announced his intention of resigning his command of the hospital, in order to join his old unit, and thus be nearer Sydney, a memorial, signed by from 200 to 300 men, was handed to him, begging him to remain.

In regard to the charges, we can at present be very brief. Dr. Schlink's parents came to Australia over 50 years ago, and have been loyal and respected citizens during this long period. His brothers and sisters and he himself were born in Australia, and he neither reads nor speaks German. All his friends and acquaintances know him a true Australian—a white man. He has never uttered disloyal statements in any club or elsewhere, and the fact that he has been in the Australian Army Medical Corps for seven years gives the lie direct to Mr. Orchard. In regard to the myths about the sick parade, the callousness and indifference, etc., there is a mass of evidence to show that these charges are the result of some malicious imagination. Mr. Orchard should give the name of his informant.

Captain Schlink has claimed the right of a British citizen for fair play and a fair trial. We join him in demanding a full enquiry, and the disclosure of the name or names of the person or persons making these slanderous statements. His name is in danger of being sullied; no man may be denied the opportunity of clearing himself. He is faced with social and financial ruin, after he has voluntarily served his country truly and well. The most precious possessions of a man are at stake. We demand a date on which he will be given an opportunity of defending his honour.

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THE TOBACCO FUND.

The subscriptions to our Tobacco Fund are falling off. We appeal to members to send in a few shillings, in order to bring cheer and comfort to our soldiers fighting in the trenches. Each packet of tobacco and cigarettes will be delivered to Australian soldiers.

Amount previously acknowledged, £24 6s.; Mrs. Boyd, Sydney, 2s.; Dr. A. A. Cohen, Sydney, 10s.; Dr. A. E. Hayward, Tas., 3s.; Dr. R. G. Plummer, South Aust., 5s.; Total, £25 6s.

WORKERS' COMPENSATION ACT, 1914.

The following announcement of the Amendments of the Regulations governing the Workers' Compensation Act, 1914 (Victoria) has been published in the *Victoria Gazette*, No. 65, under date June 9, 1915:—

Under the powers in that behalf conferred by the "Workers' Compensation Act, 1914" (Act No. 2496), His Excellency the Governor of the State of Victoria, by and with the advice of the Executive Council thereof, doth make the Regulations following (that is to say):—

1. These Regulations may be cited as the "Workers' Compensation Regulations (Amendment), 1915," and shall be read and construed as one with the "Workers' Compensation Regulations, 1914," as amended (hereinafter referred to as the "Principal Regulations').

2. In Regulation No. 28 of the Principal Regulations the words "either by reason of depreciation or" before the words "owing to portion thereof" are hereby repealed.

3. (*a*) In paragraph (i) of Regulation 37 of the Principal Regulations for the words "a fee of 7s. 6d." there shall be substituted the words "a fee of 10s. 6d."

(*b*) In sub-paragraph (iii) of the same Regulation for the words "a fee of 2s. 6d." there shall be substituted the words "a fee of 10s. 6d."

4. Paragraph (ii) of Regulation 48 of the Principal Regulations is hereby repealed, and in lieu thereof there shall be substituted the following paragraph:—

"(ii) Where, in order to examine the 'worker,' the medical referee is compelled to travel to a place distant more than two miles from his residence or such other centre as may be prescribed by the Governor in Council in addition to the above fee, 5s. for each mile beyond two distant from such residence or centre."

5. Regulation No. 4 of the "Workers' Compensation (Amending) Regulations, 1914," is hereby repealed, and in lieu thereof there shall be substituted the following Regulation:—

"4. For any certificate given under Regulation No. 2 the certifying medical practitioner shall be entitled to charge a fee not exceeding 2s. 6d."

6. Regulation No. 5 of the "Workers' Compensation (Amending) Regulations, 1914," is hereby repealed, and in lieu thereof there shall be substituted the following Regulation:—

"5. The remuneration which the certifying medical practitioner shall be entitled to charge in respect of any certificate of disablement by accident given by him under paragraph 4 of the First Schedule to the 'Workers' Compensation Act, 1914,' shall be a fee of 7s. 6d.; and where the 'worker' is unable to present himself for examination at the residence of the said practitioner an additional fee of 2s. 6d. per mile for every mile or portion thereof (after the first mile) up to three miles, and 5s. per mile for every mile or portion thereof after three miles which the certifying medical practitioner is required to travel therefrom, is to be paid."

"For a copy of any certificate given under this Regulation a fee of 1s. is to be paid."

7. Regulation No. 6 of the "Workers' Compensation (Amending) Regulations, 1914," is hereby repealed, and in lieu thereof there shall be substituted the following Regulation:—

"6. Where an employer applies under paragraph (13) of the First Schedule to the "Workers' Compensation Act, 1914," for an employé to submit himself for examination by a duly qualified medical practitioner, provided and paid for by the employer, and such practitioner be one appointed in accordance with the provisions of the Act, a fee of 7s. 6d. shall be paid; and where in order to examine the 'worker' such practitioner has to visit the 'worker,' an additional fee of 2s. 6d. per mile for every mile or portion thereof (after the first mile) up to three miles, and 5s. per mile for every mile or portion thereof after three miles which the certifying medical practitioner is required to travel is to be paid."

And the Honourable John Murray, His Majesty's Chief Secretary for the State of Victoria, shall give the necessary directions herein accordingly.

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Naval and Military News.

Dr. J. E. Donaldson has been appointed Captain in the Australian Army Medical Corps.

Sir William Osler has arranged with the medical schools of Columbia, Johns Hopkins, and Harvard Universities for the staffing by American surgeons of a new field hospital. It is suggested that 32 medical practitioners should be available, including three prominent surgeons, one physician, one pathologist, one radiographer, and one laryngologist. The universities named have agreed to bear the expense involved.

The following casualties among army medical surgeons have been announced in the *Times* of May 21, 1915:—

Lieutenant M. Pern, R.A.M.C., M.R.C.S., L.R.C.P., killed in Belgium. Lieutenant Pern qualified in 1912 from Guy's Hospital. He held the position of assistant medical officer at the Workhouse Infirmary at Portsmouth in 1913.

Lieutenant Edgar F. Edmunds, R.A.M.C., M.B., B.S., of Ellesmere Port, Cheshire, wounded in Belgium.

Lieutenant E. H. Griffin, R.A.M.C., wounded in Belgium.

Lieutenant E. C. Linton, R.A.M.C., wounded in Belgium.

Captain E. A. Sutton, R.A.M.C., M.R.C.S., L.R.C.P., wounded in Belgium.

Fleet-Surgeon George A. Waters, R.N., M.D., M.Ch.R.U.I., missing. Fleet-Surgeon Waters was on board H.M.S. *Goliath* when she was sunk on May 13, 1915, and it is feared that he has lost his life.

Abstracts from Current Medical Literature.

DERMATOLOGY.

(11) Morphœa Guttata.

J. L. Bunch describes a case of *morphœa guttata* in a child aged 11, in which there were 12 typical lesions on the shoulders, back, chest, and hip (*British Journ. of Dermatology*, March, 1915). The lesions had appeared two months previously, and subsequently several others had developed. The patches were slightly sunk below the surface, and the more recent ones were invested in a pinkish areola. They were indurated, dead white and porcelainlike. Their distribution was asymmetrical, and they did not coalesce. They varied in size from ½ to 1 inch in diameter. A slight subjective sensation of itching preceded the appearance of the eruption. The itching, however, passed off. The author gives a full account of the various cases of this condition recorded in the literature, and points out that Petges described the histology of the lesions. The epidermis is profoundly involved; the line of the interpapillary bodies is not dentelated, but formed as a more or less sinuous line; the horny layer is the seat of marked hyperkeratosis. The derma is also affected, the papillæ are barely defined, and there is a marked thickening of the fibrous tissue with rarifaction of the elastic tissue. The sudoriparous glands are atrophied, but the sebaceous glands are not involved. There is great similarity between this condition and patchy sclerodermia. Some difficulty may be experienced in the differential diagnosis between it and lichen planus sclerosus, and atrophic lichen planus. Term white spot disease appears to the author to be unfortunately chosen, inasmuch as this would apply equally well to some of the leucodermias, to certain naevi, to some cases of anæsthetic leprosy, and to vitiligo.

(12) Sclerodactylia.

F. Parkes Weber describes two cases of scelrodactylia, and contrasts them with the similar condition now known as trench frostbite (*British Journ. of Dermatology*, April, 1915). His first patient was aged 48 years, and was very poorly nourished. The skin over the toes of both feet was atrophic, shiny, and apparently tightly stretched. There was purple mottling. No pulsation was detectable in any of the pedal arteries. The calf muscles were atrophic. The tip of the fourth toe of the left foot had been cast off about seven years before, and the fourth toe of the right foot had been amputated two years later. The second toe of the right foot was partially necrosed, and some bare bone was projecting. There was an ulcer on the outer surface of the right heel. Syphilis and alcoholism were excluded. The history did not throw any light on the cause of the condition. Amputation of the second toe was effected, and the wound healed slowly. There was no bleeding at the time of the operation. Ischæmic ulceration developed in the right great toe. This was associated with great pain. In the second patient, a woman of 44, there was a condition of symmetrical, very chronic, typical atrophic sclerodermia, involving the face, neck and hands. In the last-named situation the condition presented all the characters of a severe atrophic sclerodactylia. The superficial indolent ulcers were very painful, and healed very slowly. The condition commenced when she was 32 years of age, after the birth of her fourth child. There was no venereal history. Treatment by thyroid and fibrolysin failed to improve the condition. Weber points out that the *tunica media* of the arteries are contracted and thickened, but not obliterated. In this condition the constitutional factor is apparently the main one, and the exciting cause is usually slight or obscure. On the other hand, the exciting cause in trench frost-bite is immediate and violent, and the constitutional cause of minor importance.

(13) Trichotillomania.

Hallopeau described some years ago a condition in which there was an exaggerated pruriginous sensation in all parts of the body, accompanied by an irresistible desire to pull out hairs. He called this condition *trichotillomania*. George Pernet describes two cases in which the pruritus was not marked (*British Journ. of Dermatology*, March, 1915). Both patients were highly neurotic young women. In the one the hair was coming out in a patchy and irregular way. There was no similarity to the condition met with in *alopecia areata*. The author concluded that the hairs were being pulled out, and that the condition was factitious. The patient had been subjected on several occasions for a suppositious necrosis of the lower jaw. The second patient had produced a dermatitis of the face and chest artificially by means of a liquid irritant. The loss of hair was also traced to deliberate action of the patient. There was pharyngeal anæsthesia and anæsthesia along the right border of the tongue. She was eventually cured by her mother, to whom the author disclosed the nature of her condition.

(14) Microsporon Tinea in an Adult.

In spite of the frequency in which ringworm is communicated from child to child, it is a curious fact that this condition is rarely passed on to an adult. W. J. Oliver (*British Journ. of Dermatology*, April, 1915) records a case from the London Hospital. The patient, a woman aged 32, noticed what she regarded as a patch of dirt on the scalp of her eldest child's head. She used a piece of flannel to wash it off, and at a later date used the same piece on her own head, and on the head of her three other children. One month later red rings were noticed on the eldest child's chest, and a month later still the hair began to fall out. The whole family was treated from that time for ringworm without much improvement. At the London Hospital X-rays were used, and a mercurial ointment was prescribed for the mother. Three months later some of the stumps of the hair were inoculated into glucose and maltose agar, and a typical growth of *microsporon felineum* resulted.

(15) Multiple Tumours.

E. G. Graham Little (*Proc. of the Royal Soc. of Med.*, March, 1915) relates the case of a chronic fibrosis of the fat zone, producing tumours clinically indistinguishable from fibrosarcoma. The patient was treated in Turin and Geneva 15 years previously for a nervous affection by hyperdermic injections of "phosphorus." Fifteen injections were given. Nodular swellings resulted, which persisted and increased in size. The tumours were movable over the subjacent tissue, and involved the whole thickness of the skin. A tumour was removed, and subjected to microscopical examination. It was composed of very dense fibrous tissue with a few fibroblasts. In the fibrous tissue there were large groups of irregular cells, having a vaculated cytoplasm, and a compressed, deeply stained nucleus. Some of these cells were multinucleated. They appeared to be invading the normal fat at the periphery. They were regarded as embryonic types of fat cells. The tumour was thus not a fibrosarcoma, but possibly an atypical form of liposarcoma.

(16) Parakeratosis Variegata.

H. W. Barker (*Proc. Roy. Soc. of Med.*, March, 1915) gives the details of a case of *parakeratosis variegata* in a woman, aged 38 years. Eight months before the patient noticed some red, somewhat scaly patches on her legs. There was considerable irritation, which led to scratching. Two months later the face, neck and arms became involved, and there was a good deal of perspiration. The eruption took the form of a diffuse, reddish-brown colouration, suggesting a combination of an erythema, with increased pigmentation. There were a few scattered, small, oval, white areas. On the neck the retiform arrangement was well marked. The author came to the conclusion that the case was a mixed and unusual form of Brocq's *parapsoriasis en plaques*. The involvement of the face, the severe itching, and the marked pigmentation were exceptional features. The term "parakeratosis variegata" had been introduced by MacLeod and Colcott Fox for a case presenting very similar lesions and arrangement at the root of the neck. In this case the patient had been under observation for a considerable period, and the affection had proved completely resistant to all the forms of local and general treatment that had been tried.

BIOLOGICAL CHEMISTRY.

(17) The Estimation of Urea in Urine by Means of Urease.

R. H. Aders Plimmer and R. F. Skelton (*Biochemical Journal*, February, 1914) have described a method for estimating urea in urine by means of the urease in soy-beans. The enzyme urease converts urea into ammonium carbonate. Its action is specific, so that it is without effect on the other nitrogenous constituents of urine. The method consists in mixing 50 c.cm. of water, 1 gm. of finely ground soy-bean, and 5 c.cm. of urine in a stoppered cylinder. The cylinders are connected to Allihn bottles containing a known volume of decinormal acid. The cylinders are placed in a thermostat at 37° C. and a current of air sucked through the cylinder and the acid for one hour. The rubber connexions between the cylinder and bottle are disjointed, and 1 gm. of anhydrous sodium carbonate is dropped into the cylinder. The air-current is drawn through the apparatus for another hour. The quantity of acid neutralized by the liberated ammonia is then determined by titrating the acid with decinormal alkali, alizarin red being used as the indicator. Several estimations can be carried out together by joining up the cylinders and bottles in series, and employing one air current. The estimation of the ammonia in the urine can be done at the same time. The results have been found to be more accurate than those obtained by other standard methods. Since Folin's magnesium chloride method estimates allantoin as well as urea, the amount of allantoin in urine can be obtained from the difference in the results of the two methods.

(18) Improved Hæmin Test for Blood.

Beam and Freak (*Biochemical Journal*, March, 1915) carry out the test for Teichmann's crystals in suspected stains as follows: A small amount of the material is placed in a flat tube similar to that employed for subliming arsenic, about 3 mm. by 6 mm., and 36 mm. long. A few drops of glacial acetic acid are added, and a fine cotton thread adjusted so that its upper end is near the top of the tube, and the lower end reaches to the bottom of the liquid. The thread should be everywhere in contact with the tube to which is adheres readily by being moistened with the liquid. The tube is then placed in a vertical position, and the contents allowed to evaporate slowly. It is unnecessary to heat the acid, though this can be done if desired. The crystals are formed along the length of the cotton thread. The first crystals are usually visible through a low power of the microscope in about an hour. As the liquid ascends the thread it is filtered from rust, earth and other insoluble matters. The authors find acetic acid to be the best of the many reagents that they have tried. Acetic acid without salt suffices for the test with blood-stains, fresh and old, provided that they have not been washed. It is better to use acetic acid containing 0.01% of sodium chloride as a precautionary measure. No advantage results from the substitution of other salts for the sodium chloride. Iodides cannot be used to replace chloride or bromides in the test. Where positive results have been obtained from the use of iodides the effect is probably due to impurities in the reagents employed. The difficulties often experienced in performing Teichmann's test are due chiefly to rapid evaporation of the solvent. Evaporation should be extremely slow. The test as described has been found to be equally applicable to stains fresh and old, stains partially removed by soap and water, or heated to 110° C., or mixed with earth, or old stains on rusty iron.

(19) Inactivation by Heat of Peroxidase in Milk.

S. S. Zilwa (*Biochemical Journal*, March, 1915) has measured the rate of inactivation of peroxidase in cows' milk. The presenec of peroxidase in cows' milk can be detected by the use of hydrogen peroxide and p-phenylenediamine. A dark bluish-grey tint is obtained when the reaction is positive. The peroxidase is an actual constituent of the milk, and not due to bacterial contamination. Like most enzymes peroxidase can be inactivated by heat. This fact has been used to determine whether the milk has been heated to 80° C. or higher. An investigation has been carried out to see whether the rate of inactivation could be used to detect milk pasteurized at temperatures of 70° C. and lower. It has been found the inactivation proceeds with great rapidity at 72° C. At temperatures of 70° C. and lower, the rate of destruction is so slow that this method is not applicable. The velocity coefficient for this inactivation is very large, being in the neighbourhood of 2.3 times per degree. The reaction may, however, indicate whether pasteurized milk has been overheated. Small additions of acid retard and of alkali accelerate the rate of inactivation of peroxidase by heat. The presence of salts retards, in a pronounced way, the inactivation rate. The inactivation of peroxidase in whey proceeds as a reaction of the first order.

(20) Curative Action of Yeast Against Avian Polyneuritis.

E. A. Cooper (*Biochemical Journal*, June, 1914) has obtained a solution possessed of marked curative properties towards avian polyneuritis by the autolysis of brewers' yeast. The solution retains its effective power for eight weeks at least, and is without any toxic action, even in tenfold doses. Air-dried yeast retains its curative power after storage in a tin for two years, and will undergo autolysis after storage for four months. The autolysis of brewers' yeast should afford a simple, inexpensive method of preparing a non-toxic solution suitable for the oral treatment of human beri-beri.

(21) The Chlorides in Transudates and Cerebro-spinal Fluid.

A. A. Babes (*C. R. Soc. Biol, Paris*, No. 27, July, 1914) considers that there exists an analogy between transudates and cerebro-spinal fluid from the chemical point of view. The constituents of both these liquids exist preformed in the blood in greater concentrations than in the liquids. The chlorides alone are an exception to this rule. The investigator has had the opportunity of examining the chlorides present in samples of blood, cerebrospinal fluid, plueritic fluid, ascitic fluid, and subcutaneous œdematous liquid in seven cases, six of cardiac disease and one of tuberculosis. The results show that the amounts of chlorides in the transudates are greater than in the bloods. This increased quantity of chlorides is characteristic of transudates. In this property the transudates resemble cerebro-spinal fluids which invariably show a high concentration of chlorides.

(22) Acid Secretion in Nephritis.

L. J. Henderson and W. W. Palmer (*Journal of Biological Chemistry*, May, 1915) have continued their studies of the regulation of the excretion of acid through the kidney by an investigation of forty-four cases of human nephritis. Analyses of the daily excretion of these patients on 311 days have been made, and the results compared with similar determination made on the urine of sixteen normal persons for 122 days. The results obtained have been treated statistically, so that average results alone are employed to deduce conclusions. The figures determined have been the hydrogen ion concentration; the acid excretion, or the amount of acid in the urine in excess of that combined with the urinary bases as they exist in the blood, this quantity being expressed in cubic centimetres of decinormal solution per diem; the total urinary ammonia expressed in the same manner; and the volume of urine eliminated in 24 hours. From a consideration of their results, they divide their cases of nephritis into two groups possessing the following characteristics: (1) Cases in which the volume of urine is abnormally great, its acidity abnormally intense and the total acid excretion much diminished (signs of a condition of acidosis of renal origin). This diminished acid excretion is due to a deficit in urinary ammonia, for the value of acidity plus ammonia remains precisely normal. (2) Cases in which the volume of the urine is not far from normal, the acidity high, the total acid excretion often low, but not infrequently normal. Group 1 appears to be an uncommonly well defined group of cases, which, functionally at least, are of one type. Group 2 may well consist of either one or more classes of disturbance.

British Medical Association News.

MEDICO-POLITICAL.

The annual meeting of the South Australian Branch was held in the Lister Hall, Hindmarsh Square, Adelaide, on June 24, 1915, Dr. Poulton, the Acting President, in the chair until the induction of the new President.

The annual report of the Council, together with the financial statement and balance sheet, was submitted to the meeting and adopted (see below).

The following office-bearers were elected (see *The Medical Journal of Australia*, June 19, 1915, p. 587):—

President: Dr. J. C. Verco.
Vice-President: Dr. A. F. Lynch.
Honorary Secretary: Dr. H. S. Newland.
Honorary Auditor: Dr. H. H. Wigg.
Honorary Treasurer: Dr. W. A. Verco.
Members of the Federal Committee: Dr. W. T. Hayward and Dr. F. S. Hone.
Members of the Council: Dr. R. S. Rogers, Dr. H. H. Russell and Dr. R. H. Pulleine.
Library Committee: Dr. F. S. Hone, Dr. H. Swift, Dr. A. A. Lendon and Dr. A. C. Magarey.

Dr. J. C. Verco was introduced as President amid the plaudits of those assembled.

Dr. J. B. Gunson unveiled a coloured photograph of the late Dr. A. A. Hamilton, which had been presented to the Branch by Mrs. Hamilton. Before vacating the chair, Dr. Poulton made sympathetic reference to the death of Dr. Glynn, Dr. Sangster and Dr. Gething (Chief Quarantine Officer of South Australia).

Photographs of Dr. Moore, Dr. Wyatt and Dr. William Gosse, which had been presented to the Branch by Dr. H. S. Newland, were received formally. Dr. Lendon presented a print of the members of the Council of the Royal College of Surgeons of the year 1884, among whom was Lister.

Dr. A. W. Hill, the Chairman of the Central Board of Health, opened a discussion on proposed legislation in connexion with venereal diseases. He dealt with the subject from the administrative point of view, and directed the attention of members to four points: (1) Notification of venereal disease; (2) registration and examination of prostitutes; (3) education of the public and the means for carrying this out with success; and (4) night clinics, with or without paid staffs.

It was resolved that the discussion should be postponed to a future meeting of the Branch.

A paper on the same subject, written by Dr. F. S. Hone, was read in his absence. We propose to publish this paper, together with the discussion on venereal diseases.

A vote of thanks was passed to Dr. E. W. Morris and Dr. Poulton; to the former for the able manner in which he had filled the office of President, and to the latter for having acted in the same capacity since Dr. Morris's departure for the front.

ANNUAL REPORT.

The Council has the honour to submit the following report of the work of the branch for the year ended June 30, 1915.

Membership.

The branch now consists of 245 members. Of these 22 were elected during the year.

The Council regrets to record the death of Dr. A. A. Hamilton, a past president, and member of the Council. Mrs. Hamilton has kindly presented the Branch with an enlarged photograph of the late Dr. Hamilton, to hang in the Lister Hall. The deaths of Dr. McMahon Glynn, of Kapunda, and Dr. John Ikin Sangster, jun., of Burra, are also recorded with regret.

Meetings.

The annual meeting held last June was celebrated by the opening of the new House of the Branch, and the dedication of the Lister Hall, which was performed by Sir Harry Allen, of Melbourne, who delivered an address on "Lister," and unveiled an oil painting of Lord Lister, which was presented to the branch by Dr. H. S. Newland.

Nine ordinary meetings were held, the average attendance being 29.

The proceedings of the ordinary meetings and clinical evenings included six papers, thirty-one living exhibits, and many pathological specimens were shown.

Representation.

Mr. Syme, of Melbourne, was nominated to represent the branches of Victoria, Tasmania, West Australia, and South Australia on the Council of the British Medical Association.

Dr. W. T. Hayward and Dr. F. S. Hone again represented the Branch on the Federal Committee, Dr. Hayward being re-elected chairman.

Annual Subscription.

In consequence of the increase in the subscription to *The Medical Journal of Australia*, it was decided at a special meeting of the Branch, held on April 8, 1915, that the annual subscription should be raised to £2 15s. for country members and £3 5s. for city members from January 1, 1916.

University Library.

The usual grant of £50 has been paid to the University.

Dr. J. C. Verco has presented to the Branch a set of framed prints of medical men, and Dr. A. A. Lendon an unframed print of "The Council of the Royal College of Surgeons, 1884."

The Library Committee purchased a valuable collection of ancient books from Dr. H. K. Fry.

The War.

The war has affected the Branch in common with the rest of the community, and many of our members are now serving the Empire at the front, in England and at Home.

Considerable discussion as to the best means of conserving the interests of absent members has occupied both the Council and the members at meetings, and various alterations in the *personnel* of office-bearers has taken place.

Our President (Dr. E. W. Morris) has been called to active service with the Naval Bridging Train, and Dr. B. Poulton (ex-President) has come to the assistance of the Branch until the annual meeting.

The Hon. Secretary (Dr. H. S. Newland) answered the call of the Empire last November, and Dr. A. C. Magarey has acted in his place.

The Treasurership being rendered vacant by the resignation of Dr. F. St. J. Poole, who removed to the country, was kindly undertaken by Dr. W. A. Verco.

Dr. T. G. Wilson, representative of *The Medical Journal of Australia*, has gone to the front, and his duties were performed by Dr. C. T. de Crespigny until his departure, when Dr. F. S. Hone undertook the duties.

The depletion of the Council was such that Drs. R. Brummitt, S. L. Dawkins and R. J. Verco were requested to act during the absence of Drs. H. S. Newland, T. G. Wilson and H. A. Powell.

Alcohol Resolution.

In February, 1915, the Branch passed a resolution that it was advisable for members to abstain from alcohol during the duration of the war, to influence the troops towards temperance.

Belgian Doctors' Relief Fund.

The Branch has started a fund towards helping Belgian doctors, and members have responded in a very gratifying manner, £461 8s. having been already received.

Friendly Societies.

Immediately on the outbreak of war all discussions over Lodge rates were discontinued until the restoration of peace.

Members on Active Service.

Fifty-six members of the Branch have volunteered for active service. Some have gone from England, others are in charge of transports conveying wounded invalids from the front, and the majority are serving with our troops at the Dardanelles and in Egypt.

Betts, L. O.	Cowan, D'Arcy	Fry, H. K.
Burston, S. R.	Corry, S. L.	Fleming, T. G.
Black, E. C.	Close, W. J.	Gilbert, H.
Browning, D. de C.	Corbin, Cecil	Griffiths, E. W.
Cudmore, A. M.	de Crespigny, C. T.	Godfrey, K. C.
Cavenagh-Mainwaring, W. R.	Drew, C. F.	Harvey, G. A.
	Dawson, Bernard	Hayward, L.
Corbin, John	Fooks, E. V.	Hodson, J. E.
Clayton, A. R,	Flood, J. W.	Hamilton, J. A. G.

Jermyn, F.	Marshall, C. F.	Powell, H. A.
James, W. A.	Moodie, G.	Pellew, L.
Jeffries, L. W.	Morris, E. W.	Pitcher, C. F.
Jones, Britten	Meikle, A.	Penny, H. B.
Kneebone, P. LeM.	Muirhead, J. R.	Pryde, A.
LeMessurier, F. N.	Nott, H. C.	Russell, E. A. H.
Leon, J. H.	Newland, H. S.	Rennie, H. H. C.
Strangman, C. L.	Smeaton, B.	Watson, A.
Steele, K. N.	Turner, C. Y.	Wilson, T. G.
Simmons, W. F.	Verco, J. S.	Yeatman, C.

B. POULTON, Acting President.
A. C. MAGAREY, Acting Hon. Secretary.

June 16, 1915.

Library Fund.

Year.	No. of Members	Sum Represented.
1909	77	£69 6 0
1910	81	72 18 0
1911	88	79 4 0
1912	92	82 16 0
1913	97	87 16 0
1914	98 (at 10/6 per member)	51 9 0
		£443 9 0

	£ s. d.	£ s. d.
Actual Amount Received		443 9 0
Less Amount Paid University	300 0 0	
Less Amount Paid Bookcases	62 10 0	
		362 10 0
		£80 19 0

Revenue Account for Year Ended 31st December, 1914.

December 31.	£ s. d.	£ s. d.
To Sundry Expenses—Printing, Postage, Stationery, etc.	36 10 3	
„ Suspense Dinner Account	0 8 0	
„ Legal Expenses	11 7 6	
„ Architect's and Valuator's Fees	30 0 0	
„ University Library	50 0 0	
„ Clerical Assistance	20 0 0	
„ Advertising in Papers and Journals	11 14 11	
„ Heyne, Potter—Wreath	1 1 0	
„ Caretaker—University	1 10 0	
„ "Australasian Medical Gazette"	82 19 3	
„ "Medical Journal of Australia"	80 6 6	
„ Capitation Grant Federal Committee	5 4 0	
„ "British Medical Journal" (including exchange)	229 19 0	
		561 0 5
„ Balance		582 15 5
		£1,143 15 10

December 31.	£ s. d.	£ s. d.
By Balance as on December 31, 1913		558 1 11
„ Subscriptions and Arrears	585 4 6	
„ Less Amounts Repaid—		
Medical Benevolent Fund	£15 2 6	
Medical Defence Association	5 4 0	
	20 6 6	
		564 18 0
„ Typewriting, Duplicating, etc.		3 9 6
„ Interest on Treasury Bills and Bank Accounts		17 6 5
		£1,143 15 10

Balance-sheet as on 31st December, 1914.

LIABILITIES.	£ s. d.	£ s. d.
To Sunday Creditors—		
Vardon and Sons	1 19 8	
H.S.N. (Disbursements)	2 1 6	
Medical Benevolent Fund	15 2 6	
Medical Defence Association	5 4 0	
"Medical Journal of Australia"	80 6 6	
Capitation Grant Federal Committee	5 4 0	
		109 18 2
„ Balance as at December 31, 1914		582 15 5
		£692 13 7

ASSETS. December 31.	£ s. d.	£ s. d.
By Plant, Duplicator, Books, Bookcases		109 2 6
„ Treasury Bills		100 0 0
„ Bank Balances—		
National Bank	4 9 11	
Savings Bank	348 1 2	
Commonwealth Bank	51 10 0	
Savings Bank—Library Account	79 10 0	
		483 11 1
		£692 13 7

Audited and found correct, H. HIGMAN WIGG.

A meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on June 25, 1915, Dr. Brady in the chair.

Dr. Sandes moved, in the absence of Dr. Todd, the following on behalf of the Council:—

Regulations Governing Sections for Special Branches of Medical Knowledge.

Sections of the British Medical Association, New South Wales Branch, for the study of special branches of medical knowledge may be formed under certain conditions as follows:—

1. Any number of members of the Branch desiring to form any such Section shall apply in writing to the Council of the Branch for recognition as a Section specifying explicitly the scope of work of the proposed Section. No Section shall be formed except in pursuance of resolution to that effect by the Council of the Branch, and the Council may, at any time, by resolution terminate the existence of any Section.

2. All members of any such Section must be members of the Branch, and membership shall be open to all members of the Branch.

3. The members of each Section shall appoint a Chairman, a Secretary, who may or may not also act as Treasurer of the Section, and such other office-bearers as they shall from time to time determine. All such appointments shall be reported to the Council of the Branch, and shall be subject to the approval of the Council.

4. Each member of a Section shall pay to the Treasurer of the Section an annual subscription consisting of such sum as the members thereof shall from time to time determine.

5. Ordinary meetings of a Section shall be held at such intervals and at such times as the members of the Section may from time to time determine, subject to the approval of the Council of the Branch; any such meeting may take the form of a clinical afternoon at some

special hospital, a special demonstration, or, with the special consent of the Council, may be held in conjunction with an Ordinary Meeting of the Branch.

6. The members of the committee of any Section shall be responsible for any expenditure and for any liabilities incurred by such Section.

7. On or before 31st January of each year, the Secretary or each Section shall forward to the Secretary of the Branch a report of the work of such Section for the previous year, and a balance sheet showing its financial position, together with a list of its members.

Dr. Litchfield referred to the disadvantage in which non-medical members of societies might be placed in the event of a Society becoming a Section of the Branch. The Pathological Club of Sydney would welcome the change, provided that its members could continue to enjoy the privileges of membership.

The Chairman pointed out that according to the by-laws of the New South Wales Branch of the Association, persons distinguished in science could be elected honorary associate members of the Branch, while, according to the Articles of the British Medical Association, these persons could be elected as extraordinary (complimentary) members. Dr. Litchfield therefore moved that regulation 2 be amended by the addition of the words "ordinary, honorary, associate or complimentary" after the words "members of the Branch." This amendment was seconded and approved.

A discussion followed, in which the main points raised were whether there would be any compulsion for an existing society to become a Section, and also whether the formation of Sections would affect the attendance at Branch meetings, either favourably or otherwise. The general feeling of the meeting in regard to the latter point was that by these means the members would be brought into more intimate contact with one another, and that the innovation would be advantageous to both the individual members and to the various specialistic societies. It was pointed out that no society would become a Section unless its members desired it.

The resolutions were put *en bloc*, and carried.

The following motion of the Council, which stood on the agenda paper, was withdrawn temporarily, pending the attendance of Dr. R. H. Todd, the Honorary Secretary:—

That no fee be charged for medical attendance on returned invalided soldiers for a period of six months from their arrival in New South Wales; provided that the attendance is necessary through injury received or illness incurred during military service.

The following subscriptions have been received by the Treasurer of the Queensland Branch, in aid of the Belgian Fund:—

	£	s.	d.
Amount previously acknowledged	138	13	9
Dr. Bourne, E. E., Brisbane (July contribution)	0	10	0
„ Caryosso, A. B., Brisbane (June and July contributions)	2	2	0
„ Cooper, Lilian, Brisbane (June contribution)	2	0	0
„ Davidson, G., Sandgate (June contribution)	1	1	0
„ Love, Wilton, Brisbane (June and July contributions)	8	8	0
A Member (June contribution)	2	2	0
„ Robertson, W. N., Brisbane (June contribution)	4	0	0
„ Scott, E. W. Kerr, Brisbane (July contribution)	1	1	0
„ Shaw, H. C. C., Brisbane (July contribution)	1	1	0
„ Turner, A. J., Brisbane (July contribution)	2	2	0
Total	£163	0	9

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the fortnight ending June 21, 1915:—

	Metropolitan Combined Districts. Cs.	Dths.	Hunter River Combined Districts. Cs.	Dths.	Remainder of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever	21	4	3	—	42	3	66	7
Scarlatina	175	2	13	—	167	1	355	3
Diphtheria	131	3	8	—	144	2	283	5
Malaria	7	—	—	—	—	—	7	—

SMALL-POX IN NEW SOUTH WALES.

It will be remembered that on May 18, 1915, a proclamation was published revoking the proclamation declaring New South Wales a proclaimed area under the Quarantine Act, 1897. Shortly after this announcement, two cases occurred in Kurri Kurri. Measures were adopted to limit, and, if possible, check this renewed outbreak of the disease. The population was subjected to vaccination, early notification of cases was effected, and both patients and contacts were kept under control. In spite of these precautions, other cases have arisen. There have been 12 in Kurri Kurri itself, 4 in Cessnock, 1 in Aberdare, and 1 in Standford Merthyr. The districts in which these cases have arisen have been proclaimed infected areas.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending June 10, 1915:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Totals. Cs.	Dths.
Diphtheria	43	3	47	—	93	3
Scarlatina	13	—	1	—	14	—
Enteric Fever	—	—	9	1	9	1
Pulmonary Tuberculosis	22	8	19	2	41	10

The following notifications have been received by the Department of Public Health, Victoria, for the week ending June 24, 1915:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Diphtheria	66	6	57	2	123	8
Scarlatina	6	—	3	—	9	—
Enteric Fever	1	—	7	—	8	—
Pulmonary Tuberculosis	18	7	6	4	24	11

The following notifications have been received by the Department of Public Health, Victoria, during the week ending July 1, 1915:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Totals. Cs.	Dths.
Diphtheria	66	2	37	2	103	4
Scarlatina	4	—	4	—	8	—
Enteric Fever	1	1	8	—	9	1
Pulmonary Tuberculosis	15	10	10	5	25	15

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending June 12, 1915:—

Diseases.	No. of Cases Reported.
Enteric Fever	27
Diphtheria	37
Pulmonary Tuberculosis	18
Erysipelas	6
Varicella	6
Scarlatina	4
Puerperal Fever	3
Cerebro-Spinal Meningitis	2
Total	103

The following notifications have been received by the Department of Public Health, Queensland, during the week ending June 19, 1915:—

Disease.	No. of Cases notified.
Enteric Fever	49
Diphtheria	46
Varicella	20
Scarlatina	6
Pulmonary Tuberculosis	2
Erysipelas	2
Puerperal Fever	1
Infantile Paralysis	1
Total	127

The following notifications have been received by the Department of Public Health, Queensland, during the week ending June 26, 1915:—

Diseases.	No. of Cases Reported.
Diphtheria	36
Enteric Fever	26
Scarlet Fever	5
Pulmonary Tuberculosis	7
Varicella	14
Ankylostomasis	2
Erysipelas	5
Cerebro-Spinal Meningitis	2
Total	97

INFECTIVE DISEASES.

The Official Bulletin issued by the Federal Quarantine Bureau, and dated June 10, 1915, contains the following information:—

Plague.

Three cases have been reported between March 20 and May 1, 1915, from Ceylon. Between March 26 and May 6 there were 57 cases in Egypt, with 25 deaths. Between January 1 and May 8 there were 21 cases in Hong Kong, with 19 deaths. In India during the period from March 28 to April 24 there were 119,800 cases, with 98,396 deaths. In Java, from February 28 to March 25 there were 701 cases, with 637 deaths; in South Africa, from March 30 to April 25, 7 cases were notified, and 1 person died. There were 5 cases, with 5 deaths, between the dates of April 29 and May 30, in the Straits Settlements, while in New Caledonia 4 fatal cases were reported from Bourail on May 18. Several cases of suspected bubonic plague were under observation at Salonica (Greece) around April 10, 1915. There is reason to believe that cases of plague have occurred at Asuncion, in Paraguay.

Cholera.

Fifty-five additional cases have been reported in the Dutch East Indies; 45 deaths occurred. In the Philippine Islands there were 17 cases of cholera from March 14 to May 15, with 11 deaths.

Yellow Fever.

On the arrival of the barque *Alcyon* at Fremantle, from Florida, via Bahia Blanca and Capetown, on May 25, 1915, it was reported that three members of the crew had died during the voyage between the two lastnamed ports. The captain was of opinion that these men had died of yellow fever. The members of the crew, who were said to be attacked with colic, were examined by the Quarantine Officer at Capetown. He formed an opinion confirming the diagnosis of the captain. The vessel was fumigated by the Clayton process, and fresh water supplied.

Pratique was granted at Fremantle, subject to the water tanks being emptied and to other precautionary measures being taken.

THE HEALTH OF SCHOOL CHILDREN IN TASMANIA.

The Director of Education in Tasmania has submitted his report on the progress of his Department during 1914. During the year there has been an extension of the work on medical inspection, by the appointment of two additional full-time inspectors. The medical staff of this Department now includes three full-time and two part-time medical officers and two school nurses. It is anticipated that every pupil will come under medical observation at least once in two years. The children in the schools of Hobart and Launceston are subjected to weekly medical inspection. In the extra-metropolitan area, 9,974 children have been examined individually in the course of the year. Parents have been informed of serious defects requiring medical attention. It is proposed to extend the privilege of medical inspection to the children of private primary schools, where the teacher asks for their medical examination. Special attention is directed to the unsatisfactory state of the teeth of the children. It is suggested that dentists should be appointed for schools as soon as funds permit of it.

Extracts from the reports of the medical officers are appended to the Director's report. In the Northern and North-Eastern areas, 4,623 children were examined. Of these, 136 had imperfect vision, 67 were partially deaf, and 11 were mentally defective. Postnasal growths were found in 571 children whose parents were notified of their presence. In the North-Western districts, 5,332 were inspected. Eighty children were more or less deaf, as a consequence of untreated adenoids, and 192 had vision less than $\frac{6}{12}$. Postnasal growths were found in 932 children.

In Hobart, 1,849 children, including 1,700 new pupils, were examined. Defects interfering with educational progress were discovered in 448 children. Ophthalmic examination was more stringent in Hobart, as 138 children were classed as suffering from affections of the eyes. Adenoids were recorded in 177 cases. In Launceston, 536 children were reported to their parents as being in need of medical attention. Apparently, 1,883 were examined. Defective vision was noted 43 times, and deafness 29 times. The teeth were entered as good in 296 children, bad in 201, and medium in 237 children. Postnasal growths were found in 94 children.

Vital Statistics.

VICTORIA.

The quarterly returns of the Government Statist of Victoria for the period ending March 31, 1915, has been published in the Victorian *Gazette* of June 17.

The population of the State on December 31, 1914, was estimated at 1,430,667, being 18,548 more than the estimated population on December 31, 1913. The natural increase was 19,719. There were 109,149 persons arriving by sea in Victoria during 1914, and 116,114, including 15,401 members of the expeditionary forces, departing from Victoria during the year. This yields a loss by emigration seawards of 6,965. On the other hand 5,794 more people arrived than departed by land. The loss by emigration was therefore 1,171. Victoria gained 8,819 persons from South Australia, Western Australia, and Tasmania, but lost 4,604 to New South Wales, Queensland, and the Northern Territory.

During the quarter ending March 31, 1915, 2,535 marriages were solemnized. This means that of every 10,000 persons in the State, 18 were married in the quarter. There were 3,544 births, the number of males and females being almost equal. This number is 323 less than that of the corresponding quarter of the preceding year. The birth-rate would therefore be equivalent to an annual birth-rate of 23.88 per 1,000 of population. There were 3,524 deaths registered during the quarter, which is 429 more than the number registered in the corresponding quarter of the previous year. The death-rate is equivalent to an annual death-rate of 9.34.

The Government Statist does not give full record of the causes of death outside the four large cities. He contents himself with a summarized statement of some of the infective processes and of cancer. It appears that 289 persons died of cancer in the quarter. In the corresponding quarter of 1912, 336 persons died of cancer, of 1914 299, and of 1913 290, while of 1910 there were 256, and of 1911 268. It will thus be seen that the number of deaths from cancer has varied irregularly, and that there is no distinct indication of an increase or a decrease. The number of deaths from enteric fever has remained fairly constant. The average for the first quarter of the last six years is 49, and the number given for 1915 is 43. Greater variation has occurred in the number of deaths from diphtheria, the minimum being 16 (1910) and the maximum 52 (1912). In 1915 it was 31. There were 9 deaths from morbilli, as compared with 18, 10, 21, and 0 in the corresponding quarter of 1911, '12, '13, and '14 respectively. The number of deaths from pulmonary and other tubercular diseases has been singularly constant during the six years under review, the maximum for the quarter under review being 336 in 1910, and the minimum 269 in 1915.

Greater detail is given in the returns for Melbourne, Ballarat, Bendigo, and Geelong. In regard to Melbourne, there were 169 deaths from tuberculosis, 148 from diarrhœa and enteritis, 60 from pneumonia, 32 from broncho-pneumonia, 18 from acute endo-carditis, 19 from diphtheria, 12 from simple meningitis, 12 from appendicitis, 11 from enteric fever, 9 from pertussis, 8 from acute rheumatism, 7 from

syphilis, 5 from septicæmia, 4 from paralysis, 3 from acute bronchitis, 3 from influenza, 2 from measles, 2 from dysentery, 2 from tetanus, and one each from malaria and scarlet fever. The number of deaths from measles has been lower in 1914 and 1915 than in the preceding years. In regard to affections of the cardio-vascular system, 275 cases are recorded, of which 141 were due to organic diseases of the heart, 66 to cerebral hæmorrhage, 38 to aneurysms and other arterial diseases.

Of the liver diseases causing death, cirrhosis is entered 17 times, acute yellow atrophy 3 times, and hydatid tumours twice. There were 89 deaths due to Bright's disease, and 8 to acute nephritis. One hundred and sixty-five cases of cancer caused death. In 61 instances the organ affected was the stomach or liver, in 17 cases the peritoneum or intestines, in 15 the mouth, in 15 cases the female genital organs, in 13 cases the breast, and in 4 cases the skin. In 40 cases the organ affected is not specified. There were 10 deaths associated with pregnancy and labour. Three of these are vaguely described as accidents of pregnancy; 1 was due to puerperal hæmorrhage, 4 "to other accidents of labour," 1 to puerperal septicæmia, and 1 to eclampsia.

Including congenital malformations, diseases affecting infants proved fatal 155 times. In only one case was lack of care entered as the cause of death. Death from violence occurred 111 times, and in 91 instances affecting males, and in 20 females. There were 18 instances of suicide, 17 in men, and 1 in a woman, and 5 cases of homicide.

The returns for Ballarat, Bendigo and Geelong include figures which are too small to serve a useful purpose in comparative analysis. Mention may be made of the mortality from tuberculosis, diarrhœa and enteritis, pneumonia, and enteric fever and cancer. The figures for Ballarat, Bendigo and Geelong respectively are: tuberculosis, 10, 18, and 6; diarrhœa and enteritis, 17, 19, and 20; pneumonia, 7, 6, and 3; enteric fever, 6, 3, and 2; and cancer 13, 9, and 10.

Medical Matters in Parliament.

A MEDICAL ACT.

The Attorney-General for Victoria, the Hon. D. Mackinnon, M.L.A., introduced into the Legislative Assembly on May 29, 1915, a Bill relating to certain graduates in medicine and surgery who are on war service. The object of this Bill is to enable the Medical Board of Victoria to register as legally qualified medical practitioners certain graduates in medicine and surgery of the University of Melbourne who have gone outside Victoria on military service, and to issue to them certificates of qualification without requiring them to attend personally before the Board. The second reading was taken on June 1, 1915, and the Bill passed through all its stages. At the request of the Minister of Public Works, the Bill was passed through the Legislative Council at one sitting on June 8. His Excellency the Governor gave his consent to the Bill at the Government Offices on June 15, 1915. The text of the Act is as follows:—

A BILL

Relating to Certain Graduates in Medicine and Surgery who are on War Service.

Whereas certain graduates of the University of Melbouren in medicine and surgery have gone outside Victoria on war service without having been registered as legally qualified medical practitioners under the Medical Act 1890: And whereas it is desirable to enable the Medical Board of Victoria to register as a legally qualified medical practitioner any of such persons who is duly qualified to be registered, and to issue to him a certificate of qualification without requiring his personal attendance before the said Board: Be it therefore enacted by the King's Most Excellent Majesty by and with the advice and consent of the Legislative Council and the Legislative Assembly of Victoria in this present Parliament assembled and by the authority of the same as follows (that is to say):—

1. This Act may be cited as the Medical Act, 1890, Amendment Act, 1915, and shall be read and construed as one with Part I. of the Medical Act, 1890, and any Act amending the same.

2. (1) If the Medical Board of Victoria is satisfied that any doctor or bachelor of medicine or master in surgery of the University of Melbourne who, at the commencement of this Act is absent from Victoria engaged on war service has duly obtained a diploma or other document from the said University testifying to his qualification, such doctor or bachelor of medicine or master in surgery, on payment of the prescribed fees and notwithstanding his absence from Victoria, shall be and be deemed to be and shall be entitled to registration as a legally qualified medical practitioner, and shall receive from the said Medical Board a certificate of qualification, as provided by section nine of the Medical Act, 1890.

(2) For the purposes of this section, a doctor or bachelor of medicine or master in surgery shall be deemed to be engaged on war service if he is engaged on naval or military service with His Majesty's navy or army or under the provisions of any Act of the Parliament of the Commonwealth of Australia during the war in which his Majesty is at present engaged.

TASMANIA.

His Excellency the Governor (Sir William Ellison-Macartney), in his speech at the opening of Parliament, on June 30, 1915, announced that "a Bill to provide for the more efficient administration, management, and control of hospitals will be placed before you."

Medico-Legal.

SMITH-MARR *v.* WILSON.

An action, brought by Dr. A. Smith-Marr, of Blayney, against Mrs. C. A. Wilson, of Newbridge, for the recovery of £81 12s. for medical fees, was heard on June 16, 1915, at the District Court, Bathurst.

Dr. Marr was summoned to Newbridge in December, 1914, to attend defendant's husband, who had been injured in the leg by a kick from a horse. The injury was serious, and Mr. Wilson was advised to go to Blayney Hospital to facilitate treatment. On admission to Blayney Hospital, on December 8, Mr. Wilson expressed a desire to pay his way, so as not to be treated as an ordinary patient. The patient did not progress satisfactorily, and Dr. Howse was asked, at the suggestion of the family, to perform an operation. This operation was not successful, and later, after a further operation by Dr. Marr, the patient died in February.

Dr. Marr then sought payment for his services from the deceased's estate. The fees sought included fifty guineas for the payment of Dr. Howse, and six guineas for the visit to Newbridge.

The defence was that no contract to pay medical fees had been made, but that the patient had intended to pay fees to the hospital.

Evidence was given by Drs. Marr and Bray, and no evidence was called for the defence.

After argument, His Honour gave judgement for the plaintiff for six guineas only. He expressed the opinion that plaintiff had not discharged the onus thrown on him of proving that the estate was liable to pay him, as if he were a medical man attending a patient in the ordinary way. It was clear from the evidence that Dr. Marr believed he was to be paid, and that the doctor was acting in perfectly good faith in claiming his fees. But, since the action was a claim against the estate of a deceased person, he could not find, in the absence of evidence of corroboration, that the plaintiff had made out his case.

BENDIGO HOSPITAL.

The sum of £7000 was given by the late Mr. J. B. Watson, mine-owner of Bendigo, to be spent on the death of his widow on building a wing to the Bendigo Hospital. It was stipulated that the wing was to be used for general purposes, and the donor's name was to be associated with it. Mrs. Watson died last year. The needs of the hospital have changed, and a new wing, such as was proposed, would be useless, and possibly burdensome. It is now proposed that the Hospital Committee should devote £2,000 for an Infectious Diseases Hospital, £1,500 for an operating theatre, £1,000 for installing radiators, £1,000 for an electric lift, and £1,000 for balconies for convalescent patients. An application to Mr. Justice Hodges, in the Practice Court, Melbourne, was made to permit the gift being varied. It was asked that Mr. Watson's name be applied to both the proposed buildings.

His Honor agreed that it would be a waste of money to build a general wing to the hospital if it was not wanted, and made the order as asked for.

Special Correspondence.

(From our London Correspondent).

LONDON LETTER.

The Rhodes Scholars.

The Rhodes Trustees in their statement for 1913-14 announce that the number of scholars in residence at Oxford in the course of the academic year was 177, of whom 76 were from the Dominions, 88 from the United States, and 13 from Germany. There were also in residence three ex-Rhodes Colonial scholars, of whom two were engaged in teaching; one as fellow and tutor of his College, and the other as Assistant to the Merton Professor of English language and literature, while the third was reading engineering. During the course of the academic year 1913-14, 76 scholars completed the period of their scholarships. Since the outbreak of the war in August a large proportion of the Colonial scholars in residence have taken commissions or enlisted in the Imperial Army. They have been given leave of absence, and will be allowed to resume their scholarships at the end of the war. A considerable number of ex-Rhodes scholars have also taken service in the various colonial contingents. Twenty American scholars have been asked by the International Commission for Relief in Belgium to assist in the work of distributing supplies in that country, and, subject to the consent of their Colleges, leave of absence has been granted to them for this purpose. At the beginning of the October Term, 1914, 63 new scholars, Colonial and American, came into residence.

Among the Oxford distinctions gained by scholars during the year are the following:—J. I. Osborne, Indiana, 1911 (Christ Church), Matthew Arnold Memorial Prize (for an Essay in English Literature); Lloyd Dixon, New Brunswick, 1910 (Balliol), Robert Herbert Memorial Prize (for an Essay in Colonial History); G. L. Haggen, British Columbia, 1913 (Queen's), Cobden Prize (for an Essay in Political Economy). In addition, C. H. Carruthers, Ontario, 1913 (Corpus Christi), was honourably mentioned for his work in the examination for the Boden Sanscrit Scholarship, and awarded a prize of £10 in books.

The statement contains a list indicating the lines of work taken up by the 504 Rhodes scholars who have completed their term. More than half the total have devoted themselves to law and education, 31 to medicine, 33 to the German Civil Service, 22 to the British Civil Service, and 8 to scientific research work.

The Royal Geographical Society.

At a meeting of the Royal Geographical Society, held on March 22, the President made the following statement:—

> Before proceeding to the ordinary business of the evening, I have to make an unusual, and I think I may say unprecedented, announcement to the Society. We have felt compelled to remove a name from the list of our Honorary Corresponding Members. The following resolution has been passed to-day by the Council, having before them the book by Dr. Sven Hedin, "From the Western Front," which has been published in Sweden, and which is, I regret to say, about to be published in this country. The resolution is as follows:—"The Council, having become aware that Sir Sven Hedin, K.C.I.E., a subject of a neutral State, has identified himself with the King's enemies by his actions and published statements, orders that his name be removed from the list of honorary corresponding members of the Society. The Council believe that the feeling of the majority of the Fellows of the Society will be with them in taking this step."

With the approval of the King, the Council of the Society have decided to award the two Royal medals at their disposal this year to Sir Douglas Mawson and Dr. Filippo de Filippi. The Founder's Medal is awarded to Sir Douglas Mawson for his leadership of the Australian Antarctic Expedition. Dr. de Filippi, the recipient of the other Royal Medal, known specifically as the Patron's Medal, is the well-known Italian explorer, the friend and companion of the Duke of the Abruzzi on his expeditions to Mount St. Elias in Alaska, to the snows of Ruwenzori in Equatorial Africa, and to that giant among giant peaks in the mountain ramparts of Northern India, Mount Godwin Austin.

Announcement is also made of an award of the Victoria Research Medal. This is a special gold medal, which is not awarded annually. Its recipient this year is Dr. Hugh Robert Mill, who was for many years librarian to the Royal Geographical Society. Since 1901 he has been Director of the British Rainfall Organization. He is one of the foremost exponents of the principles of scientific geography, and by his writings and lectures has done much to raise the standard of geographical education in this and other countries.

Of the minor awards at the disposal of the Society the Murchison Grant is bestowed on Captain J. K. Davis, the intrepid Antarctic navigator, who commanded both Sir Ernest Shackleton's ship the Nimrod and Sir Douglas Mawson's ship the Aurora. The Gill Memorial is awarded to Lieutenant-Colonel the Hon. C. G. Bruce, who has climbed extensively in the Himalayas during the past quarter of a century. Mr. C. W. Hobley, one of the officials of the British East Africa Administration, is the recipient of the Back Bequest. Much of existing knowledge of the geology of British East Africa is due to him, and he has also done much to promote knowledge of the native peoples and languages. Finally, the Cuthbert Peek Grant is awarded to Mr. Alan Grant Ogilvie, one of the younger generation of scientific geographers, who has already made several valuable contributions to geographical knowledge, notably in connection with Morocco.

Commemoration at Oxford.

The Hebdomadal Council of Oxford University has decided that the Encænia this year shall be held in the same manner as in the years 1901 and 1910, the years of the death of Queen Victoria and of King Edward VII. There will be no honorary degrees. The ceremony will take place in the Divinity School, and not in the Sheldonian Theatre, and the proceedings will be confined to the delivery of the Creweian Oration in Latin by the Professor of Poetry, and the recitation of prize compositions.

The Trade in Senna.

The plant from which the finest quality of senna is obtained grows in the Sudan, where the leaves and pods are collected and dried by the natives, and sold to collecting agents for export. At one time this trade was entirely British, and the produce was sold through London, but subsequently it passed into German hands, and British manufacturing chemists have had to obtain their supplies through Hamburg. It is alleged that the German exporters in Egypt have succeeded in cornering the market at various times for account not only of dealers in Hamburg, but also in New York, with the result that there has been a scarcity of senna in the United Kingdom, and the prices obtained for leaves and pods have at times been artificially raised to much above the real value, while there has also been a great deal of adulteration.

The Imperial Institute has been in communication with the chief British importers and with the Egyptian Government, and the export of senna from Egypt has now been prohibited except to the United Kingdom and France. The export of senna to Germany and elsewhere by way of neutral countries is thus prevented, and British firms are making arrangements direct with the native growers which should not only restore the trade to this country, but lower the price and secure the purity of the supply.

—o—

Correspondence.

WHITE AUSTRALIA POLICY.

Sir,—The so-called science of our universities is too limited in its scope to deal adequately with the policy of a white Australia. The "don't know," which Huxley used so effectively, has become the badge of academic knowledge; and a high authority on heredity prefaces his large book with the gibe of Balzac that heredity is a maze wherein science loses itself.

Before science took the place of religion, thoughtful men believed that all natural phenomena were, and are, the expression of the power of God. To-day, science is in the flux, and it is by no means improbable that, ere long, matter will be regarded as a latent form of energy, and

energy as the force that dominates the universe. The difference in these two beliefs is one of time. They both express the same thing under different names. They each deal with the finite and the infinite, with evolution and heredity.

The shallowness of scientific knowledge is apparent on every hand. As an example, we are told dogmatically that the cause of consumption is the tubercle bacillus; and, yet, the cause of the tubercle bacillus is ignored. It is wrapped up in vitalism, and vital processes are as holy to the biologists as the Resurrection of the Body is to churchmen.

From the time when the earth was without form and void, ceaseless combinations of energy have ruled the mineral, vegetable and animal worlds. Man—black and white—is in tune with the universe when he is in that environment which called forth his characteristics. Abundant evidence exists that the people of the northern parts of Australia are coloured. Pigment is a positive quantity that fits a man to expose himself to sun energy; and nothing but vanity is responsible for a non-pigmented man thinking that his negative state is one of superiority.

The English are righly proud of their race—its mental qualities ever aim at truthfulness and a square deal, in spite of the often quite obvious advantage of plunder and corruption. Beeause English civilization approaches true democracy in its aims, it should strive to establish, wherever it can, the principles of decent social government, which characterize it. To demand an English Australia on the colour basis is to ask Nature to stultify itself; to demand that Australia shall be controlled by the highest type of English administration is undoubtedly good for the future Australian race.

Yours, etc.,

"COSMOS."

Sir,—Dr. Pern, in his letter, declares that "Climate is not the problem of Australia," and he also asks "What do all these scientific experiments amount to when all the time white people are slowly going north?"

For an answer, let Dr. Pern refer to the report of the Administrator in the Northern Territory for the year 1913, where he will find the following statements:—

> "As regards labourers from the south becoming permanent settlers, the experience of all our departments is against the probability. Rarely indeed do men remain for over a year.
>
> "All countries of the newer world to-day are finding greater and greater difficulty in securing what is deemed to be the best class of immigrant, namely, the Anglo-Saxon and the Northern European, and it may be safely said that the extra-tropical parts of Australia can readily absorb all its available share—even with the most strenuous encouragement—for years to come. But were such induced to come to the Territory by the most liberal concessions and labour treatment, the likelihood is that as soon as many had saved a fair amount of money they would remove to the south."
>
> "My opinion is as strong as ever that our north may be developed by white peoples, but the early stages of development at least are only likely to be accomplished by immigrants who have been accustomed to working for prolonged periods in climatic conditions approaching ours. And such whites can only be found in the southern parts of Europe.
>
> "Were immigration of a good class of southern European encouraged—it being insisted that a large percentage be accompanied by their families, and the remainder more or less related to them—the nucleus of permanent settlement may be established."

If the Administrator is to be taken seriously, then one may ask, first, How is it that, after years of intimate experience of local conditions, he has nothing to offer but an opinion? If any scientific evidence is forthcoming, it is suppressed, and he discredits his opinion by suggesting the immigration of southern Europeans. Second, What evidence has he that southern Europeans would be content to become "hewers of wood and drawers of water" in Northern Territory, and there to blacken and "form the nucleus of a permanent settlement"? Third, How does he justify his description of the southern European as a white people, when they are as deeply pigmented as many of the races of southern Asia?

Southern Europeans are a dark complexion people, but the exposed parts of the body of those who live almost daily in the open air become so ingrained with pigment that it would be difficult to describe these parts any other than black. Yet Europe, in relation to the Equator, ends where Australia begins.

Is it to pander to the prejudices of a government and a people that the Administrator is prepared to call black white, so that Australia shall be white in name if not in fact? Possibly he is not responsible for this perverted colour sense, and he is relying upon the report "On the Health Condition of the Panama," published under the authority of the Minister of External Affairs, March, 1913.

For what reason it has been necessary to inquire into the health of the Panama is not obvious, as no one can deny but that the white man can live in the tropics, and live well. Anglo-Indians have lived to a good old age, and never left India. Lord Roberts was there for 40 years, and it evidently did him no harm. But no Anglo-Indian, in India, "earns his bread by the sweat of his brow," nor did the white man in Panama.

All the 40,000 unskilled labourers employed in the construction of the Canal were coloured men, and among them were 6000 southern European. Why are these Europeans described, in the report, as white men? The pigmentary conditions of their skin are not recorded, nor any other useful detail that would lead one to conclude that they were willing and contented workers in the Panama zone.

The labouring conditions of the Canal employees can be readily stated:—

(1) The actual work of digging was largely done by negroes from the West Indies (Report, page 18).

(2) The southern Europeans were no doubt employed in the lighter menial duties, but their nature and extent are not recorded.

(3) The white men were the skilled workers, and they were protected by every aid that science could afford them. Their womenfolk provided with riding horses and tennis courts. Their children with schools, teachers, transport, lunches and matrons for their supervision out of school (Report, page 19).

Throughout the report there is not a tittle of evidence to support the contention that the labour of white men can be effectively used to exploit the tropics. Yet in the face of these facts, one reads, on page 24, "The results that have been attained on the Isthmus of Panama are most encouraging, and give ample justification for the expenditure required to make railways and roads, to open up rivers, to make war on mosquitoes and generally to fit the Northern Territory to be the home of a working white race." On the strength of this assertion, the Federal Government has been inveigling white men into the Northern Territory, and now proposes to strand there the heroes of Gallipoli.

What a travesty of commonsense, or any other sense, this white Australia policy is! The Panama demonstrates no more than is to be found anywhere in the tropics.

The Panama is a monument to medical science; but black men built the canal.

Yours, etc.,

M.B. (Melb.)

THE MEDICAL JOURNAL OF AUSTRALIA.

Sir,—Permit me to offer my personal congratulations to you and your valued staff on the completion of the first year of *The Medical Journal of Australia*, and to express my sincerest wishes for its continued and increasing success. This year has been an exceptionally trying one and your difficulties have been great. May the year just entered upon see, before its end, the commencement of a great and lasting peace.

I feel an especial interest in the *Journal*, for as far back as the first Intercolonial Medical Congress, held in Sydney (1892), I moved actively in the direction of an Australian medical journal. Mr. Bruck, the then owner of the *Gazette*, was approached and found willing to sell, and many well-known men of the day were prepared to act on a committee if formed. Certain administrative difficulties

of the Congress took so much time to settle that no definite action could then be taken, beyond the moving and carrying the resolution standing in my name in the Transactions (page 62). Dr. Cumpston, in his interesting account of the growth of the *Journal* (July 4, 1914) has overlooked this incident, and his many official duties seem to have prevented his correcting the omission or acknowledging the information sent him. The action taken at this Congress opened the way for the acquirement of the *Gazette* by the New South Wales Branch a little later. A most excellent forward movement.

There are two points for which I should like to enlist the powerful influence of the *Journal*: (1) Medical registration. After all these years of Federation, we still have a Medical Board for each State, and a practitioner must be registered in each State to be legally qualified to practice in it. Surely the various Boards could have a common standard, and the registration with any one of them should be "Australian," and confer liberty to practice in any part of the Commonwealth of Australia. (2) An Australian Degree. Surely it is unnecessary that there should be a Sydney degree, a Melbourne degree, an Adelaide degree, etc., etc. This applies to Arts, Laws, etc., as well as to Medicine. There need be no interference with the vested interests of the present universities. The standard and curriculum could be settled for all by a competent tribunal drawn from all the various universities. The examinations could be conducted by a Board of Examiners drawn from the teaching staffs of the various universities. There would be no difficulty with regard to the written portions of the examinations, and any difficulties with regard to the oral part could be readily overcome. The standing given to the graduate of an Australian degree would be much better than at present. I advocated this scheme in the Adelaide papers when the Federal Convention was sitting there, prior to Federation. The present time is probably not opportune for pressing this reform. It is one that must come, and there can be no objection to mentioning the subject now.

Yours, etc.,
LEONARD W. BICKLE, F.R.C.S. (Ed.).

68 Darlinghurst Road,
Sydney, July 5, 1915.

THE ATTACK ON CAPTAIN SCHLINK.

Sir,—With reference to the very damaging statements made against Captain Schlink, A.A.M.C., in the recent attack upon him in the Commonwealth House of Representatives, I should like to urge strongly that the members and Council of the British Medical Association should use every ounce of influence and weight they possess to have the matter thoroughly investigated and decided.

Captain Schlink has, I believe, applied for a Court of Inquiry to examine and report on the matter, but sometimes these requests are pigeon-holed or postponed, and when finally the court is held the general public have become fixed in the ideas, or have lost interest in the affair and note neither the proceedings nor the finding. In such an event, irreparable damage would be done to Captain Schlink in his capacity as medical practitioner.

Some of the statements we know positively to be untrue, *viz.*:—

(1) That he is a German and of German sympathies. He was born in Australia, and has never been out of the country. As to his sympathies, I personally can testify that, having known him for fourteen years, having worked with him in the medical school and hospital, lived with him in the intimacy of the residents quarters of Royal Prince Alfred Hospital, having discussed with him all sorts of subjects, even including the subject of the German menace, years before the threat became a blow, in short, having lived with him, worked with him, played with him, talked with him for fourteen years, I have never heard him say anything which could possibly be construed into an expression of sympathy with Germany or German methods.

(2) That two of his brothers were serving in the German army. This can be demonstrated as absolutely without foundation.

(3) That he had been known to give utterance to disloyal statements in a "certain" club. As I am a member of the University Club, the only one of which I know him to be a member, and certainly the one which he most frequents, and as I have never heard him, or, on inquiry, found anybody who has heard him, make these statements, I think there can be no doubt but that this is another wicked trick of the lying jade rumour.

Everybody will understand how much damage will be done to Captain Schlink's prospects as a medical man, even though he be exonerated as an officer, unless an early and thorough public inquiry be held to report on the whole matter.

To ensure this, I should like to insist once more that it is the duty of the B.M.A. to use all means in its power to bring this court of inquiry into effect, and as soon as possible.

Members of the profession have used their influence on behalf of a member who is of German birth, education and sympathy, therefore, should not the whole body of medical men unite to defend a member of British nationality, birth, education and sympathies.

Yours, etc.,
E. H. MOLESWORTH.

235 Macquarie Street,
Sydney, July 3, 1915.

Obituary.

WILLIAM JOHN GETHING.

Dr. W. J. Gething, Chief Quarantine Officer for South Australia, died at his residence at Port Adelaide on June 22, 1915, at the age of 52. He had a very severe illness about four years ago, from the effects of which he never completely recovered. Of late he had aged considerably, and some three months ago took a trip to Java, in company with his wife. The trip did not benefit him, as was hoped, and since his return his friends have been grieved at his loss of vigour. But the sudden end, after only 24 hours' illness, was unexpected and much regretted. He was born at Port Adelaide, where his father, whose memory still lingers in Port Adelaide, was quarantine officer before him. Dr. Gething matriculated at the Adelaide University in 1878, and was admitted to the Bar in 1885. After practising law at Hahndorf for a little while, he abandoned it for medicine, proceeded to Scotland and qualified as L.R.C.P., L.R.C.S. (Edinburgh) and L.F.P. and S. (Glasgow) in 1894. He was thus the only man in South Australia who was qualified to practise in law as well as medicine. He returned to South Australia in 1895, and joined his uncle, Dr. Toll, in practice at Port Adelaide. On Dr. Toll's death during the Boer War, Dr. Gething succeeded him as Quarantine Officer at Port Adelaide. His long association with Port Adelaide and its shipping, his lengthy experience in quarantine work, and his legal training, combined to give him special qualifications for quarantine administration, and four years ago he was appointed Chief Quarantine Officer for the State, when Dr. Ramsay Smith gave up the position. In addition, he had been for years medical officer to the Port Adelaide Casualty Hospital and Government Medical Officer in Port Adelaide. His generosity and kindliness of heart will cause him to be much missed.

Personal.

It has been found that information concerning individual members of the British Medical Association in Australia, collected from sources other than direct communication from the member concerned, or notification through the Honorary Secretaries of the Branches, is unreliable, and often erroneous. The object of the Personal column is to inform members of the movements of their friends. The Editor will be greatly indebted to members if they will notify him directly, or through the Honorary Secretary of their Branch, of their movements, more especially in regard to a change of address, or the fact of starting practice, leaving the Commonwealth on an extended holiday, returning to practice, and resignation of appointments. The collaboration of members in this way will render the Personal column a reliable source of information and of interest to readers. Notices should reach Sydney on Monday morning to ensure publication in the Journal of the same week.

The death of Mr. F. Manson Bailey, C.M.G., F.R.G.S., is reported from Brisbane. Mr. Manson Bailey was 88 years

of age, and for the last thirty-four years held the position of Colonial Botanist. His work brought him recognition from a large number of countries, and he was recognized as a great authority on things botanical. At the age of 12 he arrived in Adelaide, where he spent his youth. At a later date he took up fruit growing, farming and dairying in New Zealand, and in 1861 he settled in Queensland.

Dr. W. C. W. McDowell has been elected a representative of the Auckland District Convocation on the Senate of the New Zealand University. Dr. H. D. Bamford, the Hon. J. A. Tole and Messrs. T. U. Wells and G. J. Garland have been re-elected members of the Council of the University College, Auckland.

Dr. J. Wallace Watson, of West Wallsend, New South Wales, has left for England, to offer his services to the R.A.M.C.

Medical Appointments.

Dr. G. M. Duncan has been appointed Junior Assistant Medical Officer, Lunacy Department, New South Wales.

Dr. A. A. Crooks has been appointed Officer of Health for Alberton Shire, Victoria, during the absence of Dr. J. H. Rutter on active service.

Dr. Thomas Cooksey, F.S.C., Ph.D., B.Sc., has been appointed Government Analyst for Victoria.

Dr. G. E. Aitken has been appointed Officer in Medical Charge of the Royal Military College of Australia for a term of one year, with the honorary rank of Captain, A.A.M.C. Reserve, 2nd Military District.

Dr. R. T. Paton has been appointed Director of the Sydney Hospital.

Dr. H. L. Stafford has been appointed Junior Assistant Medical Officer, Lunacy Department, New South Wales.

Dr. P. S. Clarke has been appointed Acting Sub-District Naval Medical Officer, Cairns, during the absence of Dr. C. C. Baxter-Tyrie.

Dr. A. S. Johnson has been appointed Acting Sub-District Naval Medical Officer, Albany, during the absence on leave of Dr. T. H. Robinson.

Dr. Samson Courtenay Moore has been appointed District Medical Officer and Public Vaccinator, Jarradale, Western Australia.

Dr. E. P. Thurston has been appointed District Medical Officer and Public Vaccinator, Coolgardie, Western Australia.

Dr. A. E. Morton has been appointed District Medical Officer and Public Vaccinator at Bullfinch, Western Australia.

Dr. J. G. Sheahan has been appointed Medical Officer to the Neglected Children's Depôt, Royal Park, temporarily, during Dr. J. S. Yule's absence.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xi

Women's Hospital, Melbourne, House Surgeons.

Diary for the Month.

July 13.—Tas. Branch, B.M.A., Monthly and Council.
July 14.—Melb. Pædiatric Soc.
July 14.—Western Med. Assoc. (Cowra), N.S.W.
July 16.—E. Suburbs Med. Assoc., N.S.W., General.
July 17.—N. Suburbs Med. Assoc., N.S.W., General.
July 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee, Ethics Committee.
July 21.—Vict. Branch, B.M.A., Clinical Evening.
July 21.—W. Suburbs Med. Assoc., N.S.W., Clinical Evening.
July 21.—W. Aust. Branch, B.M.A., General.
July 23.—Q. Branch, B.M.A., Council.
July 27.—Vict. Branch, B.M.A., Eye and Ear Section.
July 27.—N.S.W. Branch, B.M.A., Organization and Science Committee, Medical Politics Committee.
July 28.—Vict. Branch, B.M.A., Council.
July 29.—South Aust. Branch, B.M.A., Monthly.
July 30.—N.S.W. Branch, B.M.A., Ordinary.
Aug. 4.—North. Dis. Med. Assoc. (Tamworth).
Aug. 4.—Vic. Branch, B.M.A., Monthly.
Aug. 5 or 12.—N.S.W., North Eastern Med. Assoc.
Aug. 6.—Queensland Branch, B.M.A., Monthly.

Covers for binding *The Medical Journal of Australia* for Vol. I., 1915, can be obtained on application to the Manager, B.M.A. Building, 30-34 Elizabeth Street, Sydney. The price of a cloth cover is 2s., and of half leather 3s. 6d.; postage, 7d.

Important Notice.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
QUEENSLAND. (Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane).	Brisbane United F.S. Institute. F.S. Lodges at Longreach.
WESTERN AUSTRALIA. (Hon. Sec. 230 St. George's Terrace, Perth).	Swan District Medical Officer. All Contract Practice Appointments in W.A.
NEW SOUTH WALES. (Hon. Sec. 30-34 Elizabeth Street, Sydney).	Australian Natives Association. Balmain United F.S. Dispensary. Burwood District F.S. Institute. Canterbury United F.S. Dispensary. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows Med. Inst., Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. Mullumbimby District Friendly Societies. N.S.W. Ambulance Association and Transport Brigade. N. Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Braidwood. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Mudgee. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, and Auburn. F.S. Lodges at Wellington. Newcastle Collieries— Killingworth. Seaham Nos. 1 and 2. West Wallsend.
SOUTH AUSTRALIA. (Hon. Sec. 3 North Terrace, Adelaide).	The F.S. Medical Assoc. Incorp., Adelaide.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to "The Medical Journal of Australia" alone, unless the contrary be stated.

All communcations should be addressed to "The Editor," "The Medical Journal of Australia," B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.